

**Assessment of sexual, reproductive,
maternal, newborn, child and adolescent
health in the context of universal health
coverage in Tajikistan**

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Abstract

Achieving universal health coverage (UHC) – meaning that everyone, everywhere can access essential high-quality health services without facing financial hardship – is a key target of the Sustainable Development Goals. Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is at the core of the UHC agenda and is among the 16 essential health services that WHO uses as indicators of the level and equity of coverage in countries. In this context, WHO undertook an assessment of SRMNCAH in Tajikistan.

This report examines which SRMNCAH services are included in policies concerning UHC in the specific country context; assesses the extent to which the services are available to the people for whom they are intended, and at what cost; identifies potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and equity lens; and identifies priority areas for action. A set of policy recommendations provides the basis for policy changes and implementation arrangements for better SRMNCAH services and outcomes in the context of UHC.

Keywords

SEXUAL AND REPRODUCTIVE HEALTH

MATERNAL AND NEWBORN HEALTH

CHILD AND ADOLESCENT HEALTH

UNIVERSAL HEALTH COVERAGE

HEALTH CARE SYSTEM

QUALITY OF HEALTH CARE

DETERMINANTS OF HEALTH

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The country assessment was conducted and the report was written by Dr Susanne Carai, Dr Ketevan Chkhatarashvili, Ms Shoiria Yusupova and Ms Minhye Park, under the overall guidance of Dr Bente Mikkelsen, Director, and Dr Nino Berdzuli and Dr Martin Weber, programme managers, of the Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe.

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Abbreviations

BBP	basic benefit package
CIS	Commonwealth of Independent States
DHS	Demographic and Health Survey
GDP	gross domestic product
HPV	human papillomavirus
IMCI	Integrated management of childhood illnesses [WHO strategy]
OOP	out-of-pocket [payment]
PCV	pneumococcal conjugate vaccine
PHC	primary health care
PPP	purchasing power parity
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
STI	sexually transmitted infection
UHC	universal health coverage
UNICEF	United Nations Children's Fund

Executive summary

The Government of Tajikistan set out to achieve universal health coverage (UHC) when adopting the Sustainable Development Goals in 2015. Reforms in the health sector are under way, aimed at improving coverage and financial protection for citizens and advancing the UHC agenda. The donor landscape is varied and includes many donors with different types of funds for projects; the government is thus in the challenging position of aligning donors behind a systematic approach to the health sector and the health of the population in Tajikistan.

To delineate which sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services are included in policies concerning UHC, an applied health system assessment was conducted in October 2019 by WHO in collaboration with the Ministry of Health and Social Protection of Tajikistan. The assessment used a tracer methodology and an equity lens to:

- assess the extent to which SRMNCAH services are available to the people for whom they are intended, and at what cost;
- identify potential health system barriers to the provision of SRMNCAH services;
- identify priority areas for action collaboratively and engage in a policy dialogue.

The tracers used were:

- antenatal care, with a focus on pre-eclampsia;
- sexually transmitted infections (excluding HIV);
- neonatal transport;
- case management of common childhood conditions, with a focus on pneumonia;
- adolescent-friendly health services (sexual and reproductive health);
- immunization.

WHO's six building blocks of UHC were used as an analytical framework for the findings to aid identification of barriers and challenges for access to and utilization of SRMNCAH services. The assessment included a desk review of national documents and policies and key informant interviews with stakeholders, policy-makers, patients and health care professionals at primary and secondary health care facilities in urban and rural settings. Unfortunately, visits to tertiary care institutions as outlined in the assessment methodology were not possible.

The findings in relation to the six tracer interventions point to a number of health system constraints.

Antenatal care, with a focus on pre-eclampsia

Pre-eclampsia is estimated to affect 2–8% of all births. At primary health care (PHC) facilities and health houses (the first point of contact in rural areas) where pregnant women are routinely tracked, providers often stated that no or very few cases of pre-eclampsia had been diagnosed in recent years. This points to problems with the detection of pre-eclampsia, which indicates issues with the quality of antenatal care provided. This finding was corroborated by key informants at the referral level, who stated that women with pre-eclampsia arrive late and without proper management, indicating problems with health workers' skills at the primary care level.

Key informants identified lack of equipment (such as urine analysis/test strips) and lack of knowledge and skills of primary care providers to detect and manage the condition as causes for these findings. Maternal mortality in Tajikistan is one of the highest in the WHO European Region, and pre-eclampsia/eclampsia is among the leading causes of maternal death. Improvements in early identification at the primary care level, timely referral and proper management could prevent a significant proportion of maternal deaths.

Sexually transmitted infections

In the light of advances in rapid tests moving towards testing and treatment at the point of care, the assessment revealed deficiencies in availability of sexually transmitted infection (STI) services at the PHC level, leading to multiple referrals and fragmentation. In some districts, even first-level hospitals do not have the resources to manage STIs but have to refer patients.

Laboratories are private, and patients required to pay for testing. Medicines for the management of STIs are not covered by the government, and prescribed treatments need to be purchased by the patient at a pharmacy. These findings point to a lack of services at the PHC and referral level, and a need for out-of-pocket (OOP) expenditure for diagnosis and treatment.

Neonatal transport

Neonatal transport is a critical phase of perinatal care, requiring a specialist team and equipment to ensure maximum safety and efficiency in provision of care for sick neonates. In Tajikistan neonatal transport often has to be organized privately by parents/family, as the number of emergency vehicles is insufficient. Those vehicles that are used for neonatal transport are often not equipped properly, and the capacity of members of transport teams is limited. No helicopters are available for emergency transport.

With a significant proportion of deliveries taking place at home, swift transport mechanisms in the case of emergencies are particularly important to save lives. Specific data monitoring transfer times and status of the neonates arriving are not collected. These findings point to a lack of a mechanism for primary stabilization of sick neonates, referrals, equipment and capacity for neonatal transport.

Case management of common childhood conditions: cough and pneumonia

According to key informants, the most frequent complaint of children presenting at polyclinics is viral respiratory tract infections. Doctors carry out home visits if required. Treatment prescribed is often not evidence-based and not in line with international guidelines, but includes medication with unclear benefits, such as interferon therapy, intramuscular or intravenous vitamin injections and antihistamines for viral cough. Prescribed medications must be purchased in private pharmacies and paid for by the parent after the child reaches 1 year of age, regardless of whether the patient is treated as an inpatient or outpatient.

During hospital ward visits there seemed to be excess bed capacity, as wards were predominantly empty. A regulation has been put in place aiming to reduce polypharmacy, which restricts doctors to prescribing a maximum of five drugs at a time. It seems, however, that prescribing of multiple and invasive drugs remains prevalent. Non-evidence-based practices of prescribing unnecessary medication contribute to the high share of OOP payments.

Immunization

Vaccination coverage is reportedly very high, while the Demographic and Health Survey of 2017 reported coverage of 82%. Key informants stated that there are no problems with vaccine hesitancy. Pneumococcal conjugate vaccine and human papillomavirus vaccine have not been introduced. Delays in vaccine supplies only occur occasionally.

Adolescent-friendly health services (sexual and reproductive health)

Adolescent birth rates are high in Tajikistan: of 1000 girls aged 15–19 years, 54 give birth. Sexual and reproductive health services for adolescents and policies and interventions focusing on adolescents are a major challenge. A network of 21 adolescent-friendly centres with specifically trained providers is available, but the age of consent for accessing medical services at these health care centres is 18 years: without parental consent, health care providers are not allowed to provide services to adolescents. While in most cases parental involvement would be beneficial for the adolescent, in certain circumstances it can be detrimental to their

health and well-being, particularly when concerning sexual and reproductive health. In fact, if a pregnant girl turns to the adolescent-friendly health centres for help, law enforcement is called if she is younger than 16 years, and parents are called if she is younger than 18 years. The United Nations Convention on the Rights of the Child, signed by Tajikistan, clearly states that the best interests of the child and adolescent should be the primary consideration of the health care provider. Furthermore, absence of a policy on sexuality education leaves adolescents with little support and few options for accessing information on sexual and reproductive health.

Other services delivered to adolescents consist mainly of routine screening, which is without proven benefit, rather than services according to global standards for quality health care services for adolescents.

Dispenserization visits (a comprehensive system of examination and surveillance for all types of illness in the population) are mandatory and take place annually for all children aged 0–18 years, including adolescents.

Health system challenges identified

The following root causes were identified when analysing the findings in relation to the health system essential building blocks of UHC.

Increasing the public share of health financing is a critical reform area. Public spending on health is currently low compared to other countries in the WHO European Region, both in relative terms as a percentage of gross domestic product and in absolute terms in United States dollars per capita reflecting purchasing power parity. The limited allocation of public resources to the health sector is reflected in low salaries of health workers in the public sector and high OOP payments for health care. Monthly salaries of health personnel are low, at US\$ 85–125 for PHC doctors and US\$ 62–84 for nurses. Spending on medicines accounts for 37% of OOP payments; the remainder is spent on consultations and laboratory tests. The practice of informal payments is reported at all levels. Reliance on informal payments to supplement salaries may – at least in part – explain non-evidence-based treatment and prescribing practices.

The private sector has grown rapidly in recent years. While informal payments may be less likely in the private sector, this trend is causing widening inequities and is likely to be leading to supplier-induced demand.

Reorienting service delivery away from hospital care and towards primary care is necessary to improve health outcomes and generate efficiency savings. The current system remains biased toward hospital care, leaving PHC underfunded and underdeveloped. This is shown by the limited services available at the PHC level. Key diagnostic tests (such as urine analysis, blood tests and ultrasound) are currently not consistently available in PHC, and patients are routinely referred for essential diagnostic and treatment services (such as insertion of intrauterine devices and testing and treatment of STIs), leading to fragmentation of services and a lack of population trust in PHC's ability to provide services. Screening for and treatment of iron deficiency anaemia, folic acid supplementation and guidance on modifiable lifestyle risks such as malnutrition and obesity are areas of high-impact intervention, particularly during preconception care and pregnancy, but they are currently underutilized by PHC. At the same time, dispenserization and mandatory premarital screenings are carried out that are costly and not evidence-based.

The system still has a relatively high number of hospital beds and significant overcapacity. Bed occupancy rates in Tajikistan are 66.4%, with an average length of stay of nine days; this points to inefficiencies in use of resources. Combined with non-evidence-based resource-intensive activities, such as mass screening, it constitutes significant scope for efficiency gains.

Improving health workforce capacity at the PHC level to deliver essential SRMNCAH services and rational distribution of health personnel should be a key policy priority. PHC doctors and nurses in Tajikistan are not always skilled; they may lack confidence in delivering essential SRMNCAH services, causing multiple referrals and fragmentation of services. Primary care providers have to play a critical role in supporting underserved patients in both rural and urban settings. For family doctors and general practitioners to fulfil this role, the task profile

needs to be expanded, and preservice medical education, postgraduate training and continuing professional development prioritized in key areas of population health. While staff shortages were mentioned by several key informants, most doctors interviewed had seen between two and four patients that day. Doctors reported seeing on average four or five patients a day (most saw between zero and 12 patients a day; only one doctor reported seeing up to 30).

The number of paediatricians per 100 000 population in Tajikistan is above the average for the WHO European Region (22 versus a regional average of 19). Numbers of general practitioners/family doctors were not available, and the number of nurses was below average (391 versus a regional average of 691 per 100 000 population). While some rural areas may have shortages of doctors, nurses and midwives, in the areas visited the assessment found high doctor:patient ratios. Many different specialists work at the PHC level, including vaccination specialists who are only responsible for vaccinating children, and heads of reproductive health centres, HIV centres, healthy lifestyle centres, Integrated management of childhood illnesses centres and so on.

Modernizing health systems, improving health outcomes and reducing inequities are within reach, if sufficient resources are efficiently allocated and the benefits provided by the government realistic, transparently selected and evidence-based. PHC should be strengthened to allow provision of comprehensive SRMNCAH services; health care providers should be enabled to adhere to evidence-based guidelines; and the private sector should be regulated appropriately. With careful planning and coordination, the Ministry of Health and Social Protection can align partners and donors to implement the changes required to address the findings of the assessment; this would result in much needed improvements of the health system and services for women, children and adolescents.

Introduction

Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.¹ This definition of UHC embodies three related objectives:

- equity in access, meaning that everyone who needs health services should get them, not only those who can pay for them;
- health services of good enough quality to improve the health of those receiving services; and
- protection against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.

Achieving UHC is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015.

Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is at the core of the UHC agenda and is among the 16 essential health services in four categories that WHO uses as indicators of the level and equity of coverage in countries. Essential SRMNCAH services used as indicators for UHC are:

- family planning
- antenatal and delivery care
- full child immunization
- health-seeking behaviour for pneumonia.

An assessment of SRMNCAH in the context of UHC was conducted in Tajikistan on 21–26 October 2019. The specific objectives of the assessment were to:

- delineate which SRMNCAH services are included in policies concerning UHC in the specific country context;
- assess the extent to which the services are available to the people for whom they are intended and at what cost;
- identify potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and an equity lens;
- highlight good practices and innovations in the health system, with evidence of their impact on SRMNCAH services;
- identify priority areas for action and develop policy recommendations jointly with the country to address health system barriers to the provision of SRMNCAH services.

The assessment was carried out on behalf of the WHO Regional Office for Europe, and it is the intention that similar assessments will be conducted in other countries in the Region.

¹ Universal health coverage [website]. Geneva: World Health Organization; 2019 (http://www.who.int/universal_health_coverage/en/, accessed 21 November 2019).

Methodology

A methodological approach was developed prior to the country visit and underwent several revisions. A series of assessments took place from September 2018 to March 2019 in the Republic of Moldova, Kyrgyzstan, Albania, Romania, Kazakhstan and Azerbaijan. The steps in the assessment included:

- a preliminary document review, including health policy and strategy documents, sexual and reproductive health and child and adolescent health strategy documents, UHC guiding documents, service package descriptions and similar;
- a country visit, including:
 - interviews with policy-makers from the Ministry of Health and Social Protection, health facility managers (primary health care (PHC) and hospital), service providers (doctors, nurses and others) and beneficiaries (patients, clients);
 - visits to health care facilities at primary, secondary and tertiary levels;
- a presentation and discussion of findings and recommendations with key stakeholders at the end of the visit.

Semi-structured questionnaires were developed to conduct interviews with key informants such as:

- representatives of the Ministry of Health and Social Protection;
- health facility managers (hospital and PHC);
- health workers including nurses, doctors, midwives, where applicable;
- patients and clients, including adolescents;
- partners and stakeholders, including representatives of the United Nations Children's Fund (UNICEF) and United Nations Population Fund.

Tracer interventions

Given the limited amount of resources and time available, six tracer interventions were identified and analysed in depth to assess the extent to which services are available to the people for whom they are intended and at what cost. These were:

- antenatal care
- sexually transmitted infections (STIs) (excluding HIV)
- transport of sick neonates
- case management of common childhood conditions
- adolescent-friendly health services (sexual and reproductive health)
- immunization.

The findings are analysed and reported according to WHO's six building blocks of UHC (Fig. 1).

Fig. 1. The building blocks of UHC



Source: Universal health coverage [website]. Geneva: World Health Organization; 2019 (http://www.who.int/universal_health_coverage/en/, accessed 11 March 2020).

Limitations

The methodology aims to triangulate information through document reviews, visits to health facilities and interviews with policy-makers, health managers, providers and clients. The depth of the assessment depends on the completeness of documents provided by the Ministry of Health and Social Protection and partners, as well as the extent to which the health facilities visited and key informants interviewed are representative and reflect the national context and situation. The appraisal of tracer interventions and health systems barriers and challenges represents the judgement of the assessment team, based on the information obtained.

Country context

Tajikistan is a former Soviet country in central Asia that became independent with the dissolution of the Soviet Union in 1991. A civil war followed, with many casualties and damage to infrastructure, only ending in 1997. Since then, Tajikistan has experienced political stability and economic growth, although it remains the poorest country in the WHO European Region, with gross domestic product (GDP) per capita of only 3313.5 current international dollars reflecting purchasing power parity (PPP) – less than 20% of the European average.

The terrain is mainly mountainous, with some parts of the country difficult to reach – in particular in winter. Almost three quarters of the country's 9.1 million population live in rural areas. The population is much younger than the average in western Europe, with 37% aged between 0 and 14 years in 2018.

Table 1 sets out some key indicators on SRMNCAH in Tajikistan.

Table 1. Key SRMNCAH indicators

Socioeconomic indicator	Value	Year
Population, total (thousand) ^a	9100	2018
Population growth (annual %) ^a	2.5	2018
Population ages 0–14 years (% of total) ^a	36.8	2018
Life expectancy at birth, total (years) ^a	70.7	2017
Health expenditure indicator	Value	Year
Total health expenditure as a proportion of GDP (%) ^a	7.2	2018
Current health expenditure per capita (current international dollars, reflecting PPP) ^a	249.7	2018
Domestic general government health expenditure as a proportion of total government expenditure (%) ^a	6.1	2018
UHC indicators for tracer interventions	Value	Year
Family planning (proportion of demand satisfied with modern methods among women 15–49 years who are married or in a union (%)) ^b	52.1	2018
Antenatal care coverage (women aged 15–49 years who received four or more antenatal care visits (%)) ^c	64.2	2017
Full childhood immunization (proportion of 1-year-old children who received three doses of diphtheria-tetanus-pertussis vaccine (%)) ^b	96	2018
Health care-seeking for pneumonia (proportion of children ill with symptoms of acute respiratory infection taken to a health care provider for advice or treatment (%)) ^c	69	2017
SRMNCAH indicator	Value	Year
Maternal mortality ratio (per 100 000 live births) ^b	17	2017
Under-5 mortality rate (per 1000 live births) ^d	34.8	2018
Neonatal mortality rate (per 1000 live births) ^d	15.3	2018
Adolescent birth rate (per 1000 girls aged 15–19 years) ^b	54.3	2016

Sources:^a World Bank Open Data [online database]. Washington DC: World Bank; 2020 (<https://data.worldbank.org/>);^b The Global Health Observatory [online database]. Geneva: World Health Organization; 2021 (<https://www.who.int/data/gho/data/indicators/>);^c Tajikistan: Demographic and Health Survey 2017. Dushanbe: Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health and Social Protection and ICF; 2018 (<https://dhsprogram.com/publications/publication-FR341-DHS-Final-Reports.cfm>);^d United Nations Inter-agency Group for Child Mortality Estimation [online database]. New York: United Nations Children's Fund; 2021 (<https://childmortality.org/data/>).

All accessed 7 April 2021.

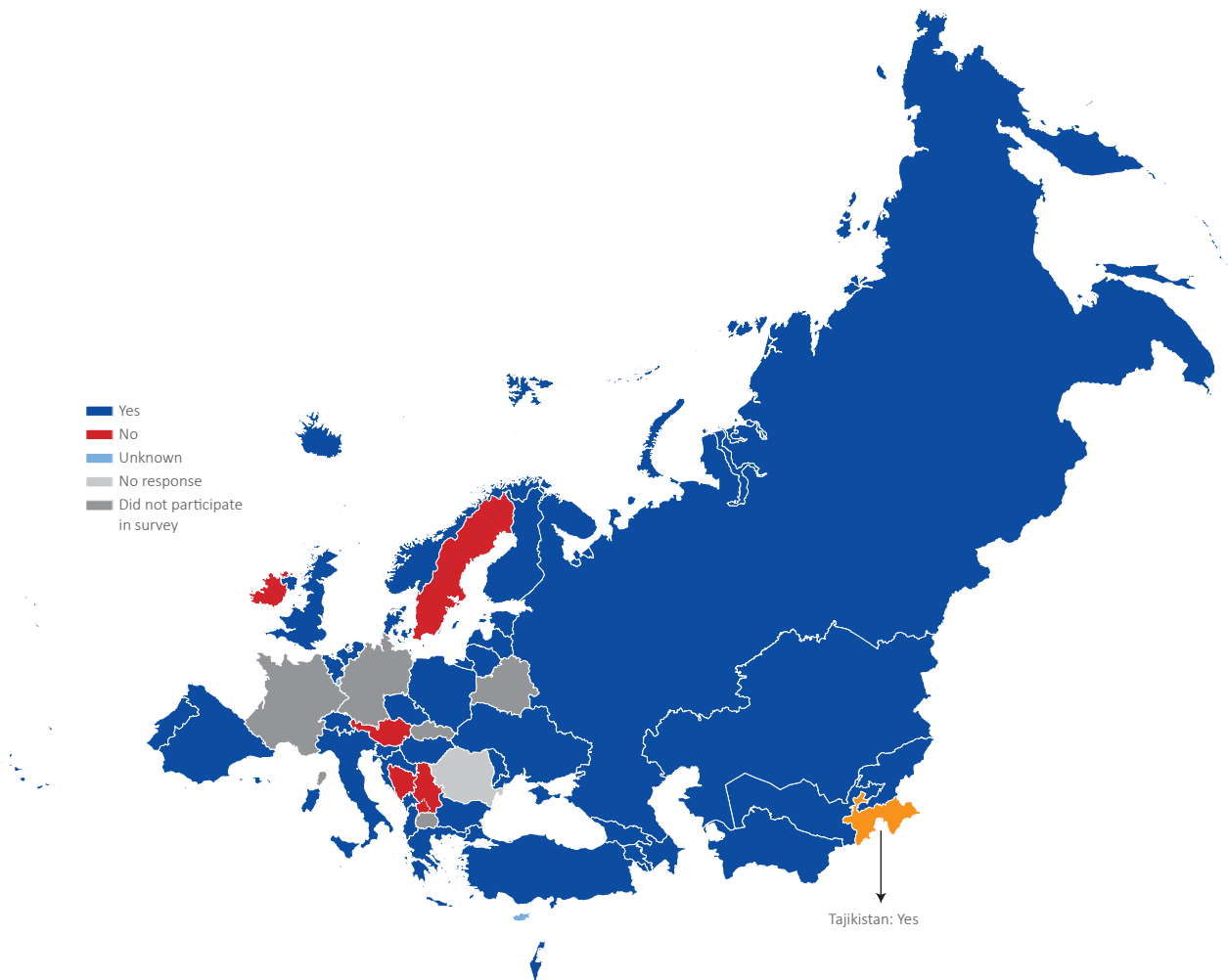
The Tajik health care system is characterized by duplication of functions among agencies and administrative levels, and fragmented institutional set-up. Health facilities exist at the national, oblast (regional), rayon (district) and jamoat (municipal) levels, and each performs similar and often overlapping roles.² Further, specialized health services for specific disease groups exist through vertical programmes, and some ministries – including the Ministry of Defence and Ministry of Internal Affairs – run their own health services.³

² Khodjamurodov G, Sodiqova D, Akkazieva B, Rechel B. Tajikistan: health system review. *Health Syst Transit*. 2016;18(1):1–114.³ Rechel B, Ahmedov M, Akkazieva B, Katsaga A, Khodjamurodov G, McKee M. Lessons from two decades of health reform in Central Asia. *Health Policy Plan*. 2012;27(4):281–7.

Findings

Tajikistan reported that a national UHC policy or strategy exists (Fig. 2), but the relevant policy or strategy document was not shared with the assessment team; nor did key informants at the national level seem to be aware of it.

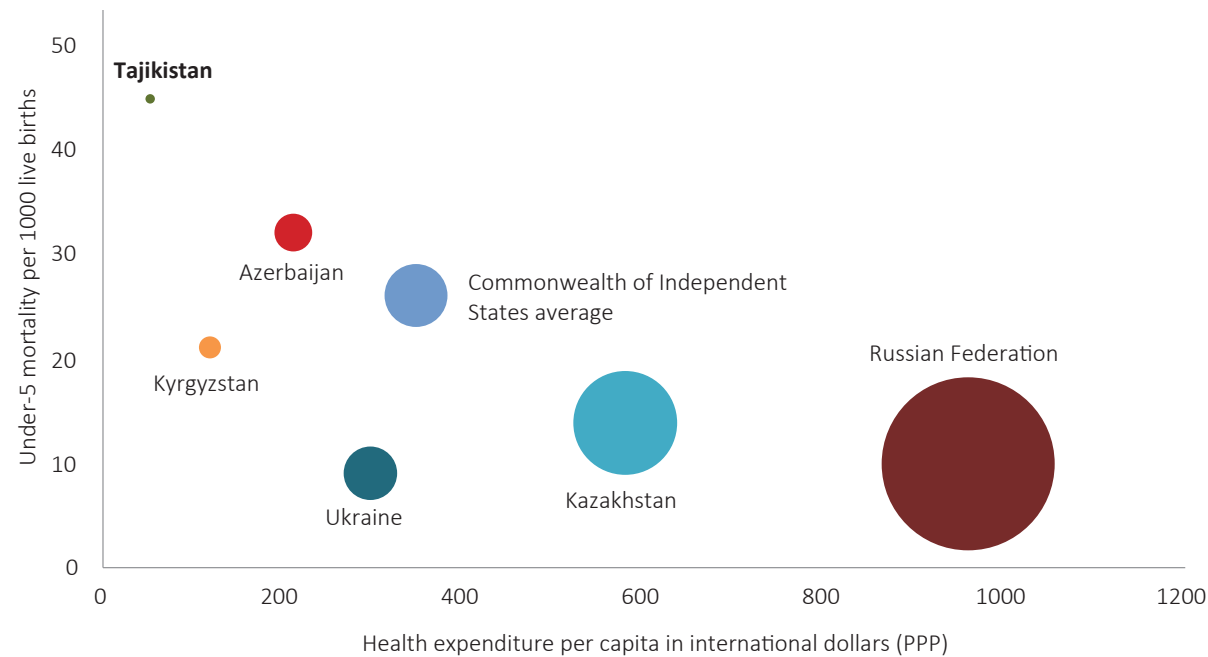
Fig. 2. Countries in the WHO European Region with/without a national UHC policy or strategy



Source: National universal health coverage policy or strategy exists. In: European Health Information Gateway [online database]. Copenhagen: WHO Regional Office for Europe; 2019 (https://gateway.euro.who.int/en/indicators/ehealth_survey_1-national-uhc-policy-or-strategy-exists/visualizations/#id=31680, accessed 11 March 2020).

Estimated under-5 mortality is relatively high in Tajikistan compared to the averages in the Commonwealth of Independent States (CIS) and European Union, as well as to other countries in the WHO European Region. Further, health expenditure in international dollars, reflecting PPP, is very low (Fig. 3).

Fig. 3. Under-5 mortality and health expenditure in Tajikistan and other countries in the WHO European Region



Note: bubble size relates to health expenditure in international dollarS, reflecting PPP.
Source: European Health for All database (HFA-DB). In: European Health Information Gateway [online database]. Copenhagen: WHO Regional Office for Europe; 2020 (<https://gateway.euro.who.int/en/datasets/european-health-for-all-database/#health-care-utilization-and-expenditure>, accessed 11 March 2020).

The pace of health reforms in Tajikistan has been slow compared to other former Soviet republics. The health care system is still shaped by the country’s Soviet legacy, with multiple pilot projects of health care systems in different regions of the countries, supported by international partners.

The biggest challenge has been to direct adequate resources to the health care system. This has been an aim of all reforms planned and implemented in the country since independence, which can be grouped into four stages (Fig. 4).

Fig. 4. Reform stages in Tajikistan

1993–1996	• Key elements of the future reform strategy (medium- and long-term) identified
1997–2001	• Implementation of consecutive plans of action for the strategies developed
1997–2001	• Implementation of a number of reforms, including in the areas of PHC, hospital care, institutional capacity, health information systems, immunization and health care financing
2010–2020	• Adoption of the comprehensive National Health Strategy 2010–2020, with the priorities of governance, health care financing, resource generation and service delivery

Sources: Khodjamurodov G, Sodiqova D, Akkazieva B, Rechel B. Tajikistan: health system review. Health Syst Transit. 2016;18(1):1–114; Akkazieva B, Tello J, Smith B, Jakab M, Krasovsky K et al. Better noncommunicable disease outcomes: challenges and opportunities for health systems – Tajikistan country assessment. Copenhagen: WHO Regional Office for Europe; 2015 (<https://apps.who.int/iris/handle/10665/145680>, accessed 23 March 2021).

In the absence of sufficient financial resources and clear direction for action, however, the process has not been successful and has not yet achieved the set goals.

Health system governance for SRMNCAH

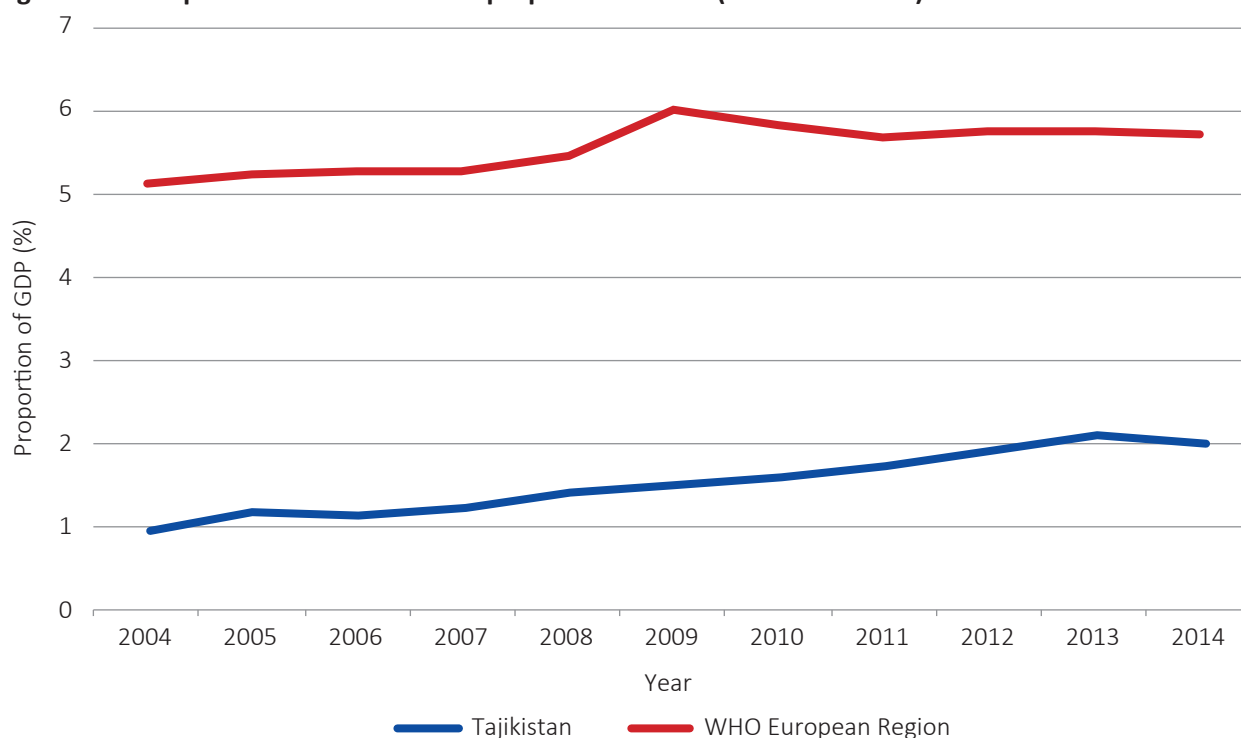
The donor landscape is varied and includes many donors with different types of funds for projects; the government is thus in the challenging position of aligning donors behind a systematic approach to the health sector and the health of the population in Tajikistan.

Mandatory health insurance does not exist in Tajikistan, and voluntary health insurance is almost non-existent. Attempts have been made to implement a mandatory health insurance scheme, but it has been delayed numerous times.

The government has defined a benefit package of services to be provided to certain groups of beneficiaries. The groups relevant to this assessment include children under 1 year, disabled children under 5 years, orphans (children in foster care and those without any type of parental care) and children under 5 years with acute respiratory infection and diarrhoeal disease (corresponding to services included in WHO's Integrated management of childhood illnesses (IMCI) strategy). The benefit package is only provided in 14 of the 58 districts in the country, however.

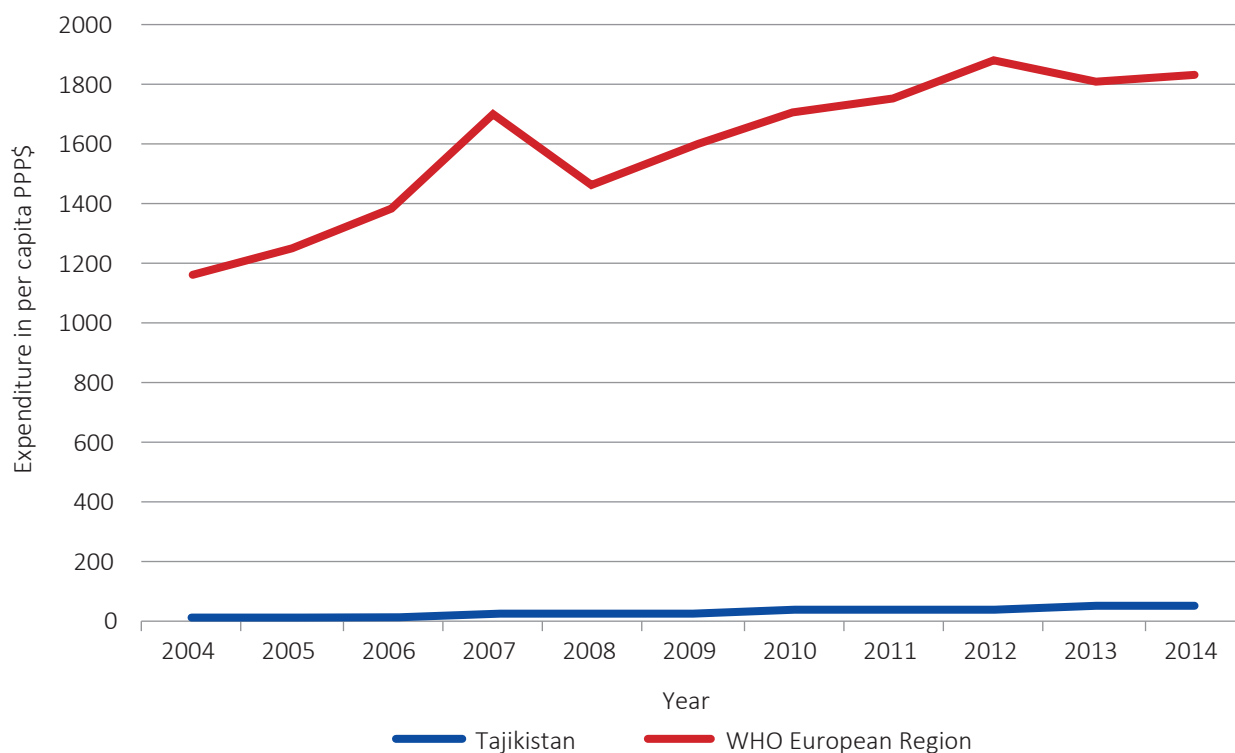
Compared to the average in the WHO European Region, Tajikistan's public spending on health is low both in relative terms as a percentage of GDP (Fig. 5) and in absolute terms in US dollars per capita, reflecting PPP (Fig. 6). As a consequence, out-of-pocket (OOP) expenditure and informal payments for health are very high, at 66% of current health expenditure in 2016 and 63% in 2017 (see also the section on health system financing).

Fig. 5. Public expenditure on health as a proportion of GDP (WHO estimates)



Source: European Health for All database (HFA-DB). In: European Health Information Gateway [online database]. Copenhagen: WHO Regional Office for Europe; 2020 (<https://gateway.euro.who.int/en/datasets/european-health-for-all-database/#health-care-utilization-and-expenditure>, accessed 11 March 2020).

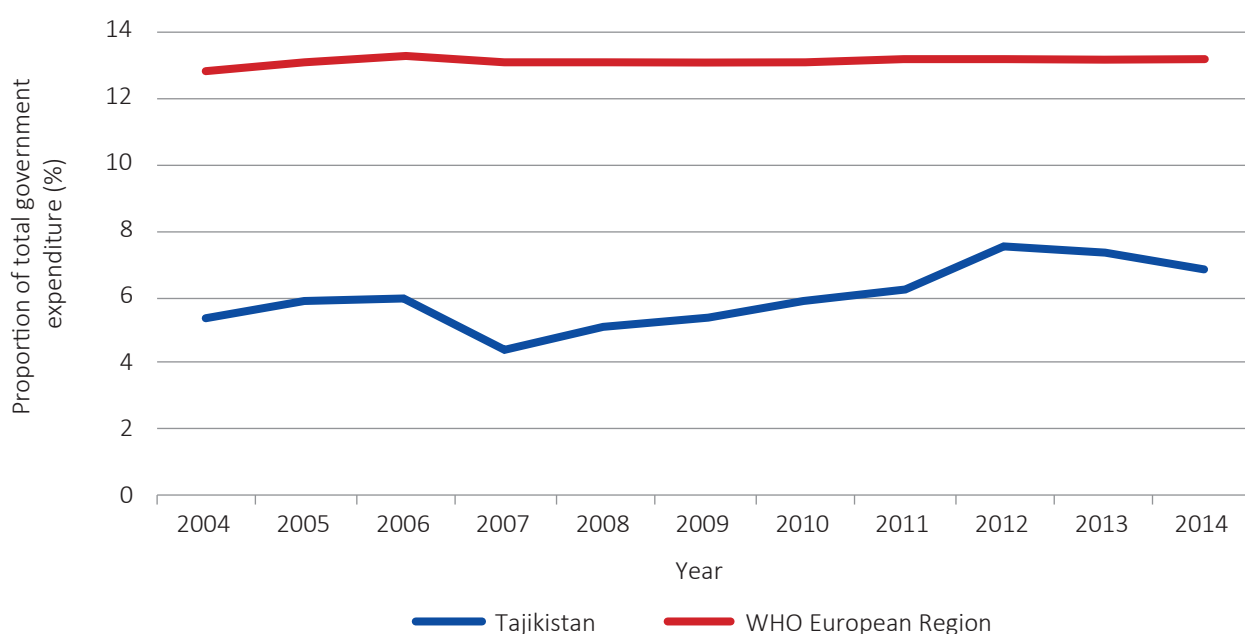
Fig. 6. Public expenditure on health per capita (WHO estimates)



Source: European Health for All database (HFA-DB). In: European Health Information Gateway [online database]. Copenhagen: WHO Regional Office for Europe; 2020 (<https://gateway.euro.who.int/en/datasets/european-health-for-all-database/#health-care-utilization-and-expenditure>, accessed 11 March 2020).

Government expenditure on health as a proportion of total government expenditure is also low in Tajikistan (Fig. 7), indicating prioritization of sectors other than health.

Fig. 7. Public sector expenditure on health as a proportion of total government expenditure, WHO estimates



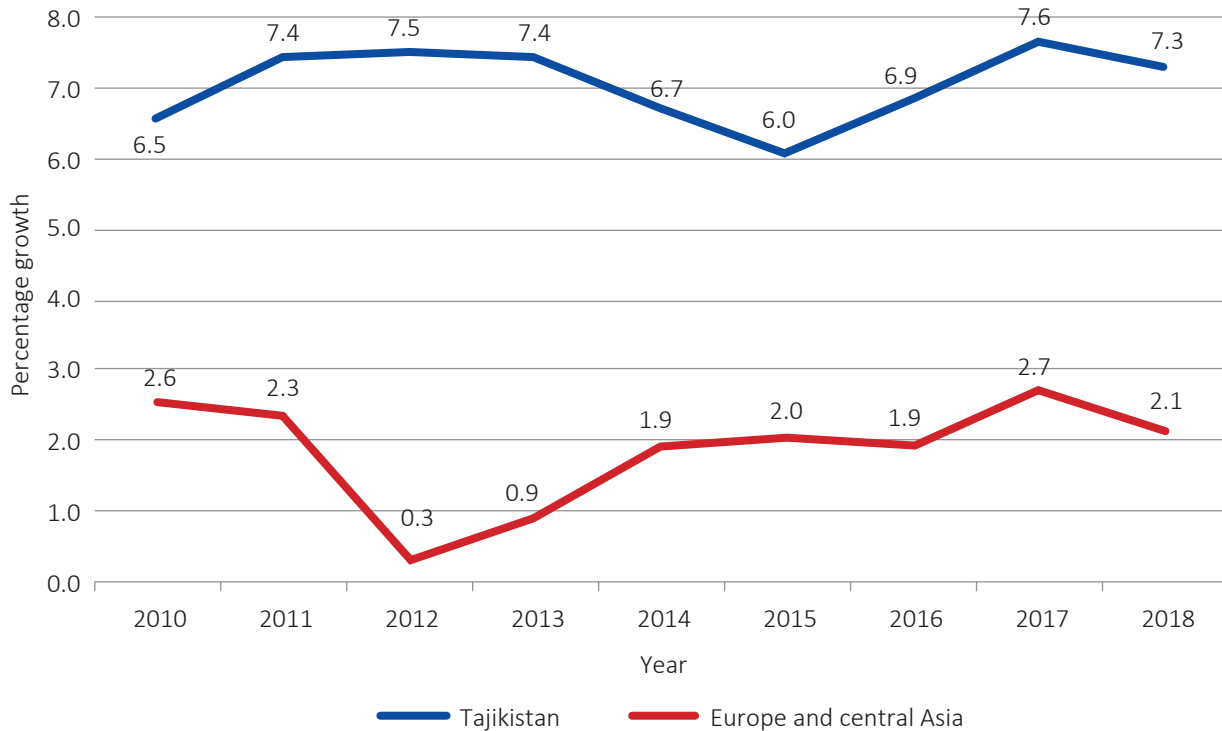
Source: European Health for All database (HFA-DB). In: European Health Information Gateway [online database]. Copenhagen: WHO Regional Office for Europe; 2020 (<https://gateway.euro.who.int/en/datasets/european-health-for-all-database/#health-care-utilization-and-expenditure>, accessed 11 March 2020).

Health system financing for UHC of SRMNCAH

Relatively low spending on health with high OOP expenditure and informal payments

Over the past decade Tajikistan has made steady progress in reducing poverty. Since 2010 its economy has grown at an average rate of 7% annually, which is much higher than the average across eastern European and central Asian countries (Fig. 8).⁴

Fig. 8. Annual GDP growth

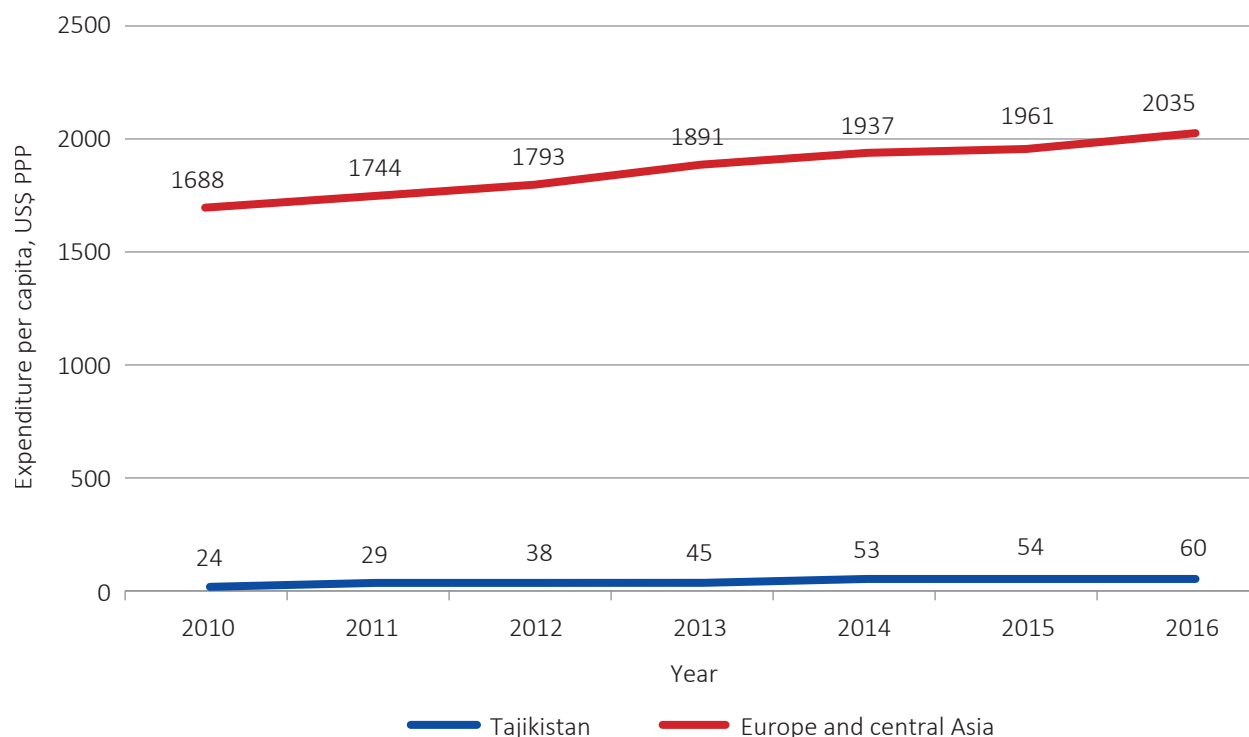


Source: World Bank Development Indicators [online database]. Washington DC: World Bank Group; 2020 (<https://databank.worldbank.org/source/world-development-indicators/preview/on#>, accessed 11 March 2020).

Despite this economic growth, the Tajik government still spends the lowest amount per capita on health among eastern European and central Asian countries (Fig. 9).

⁴ The World Bank in Tajikistan: country context. In: The World Bank [website]. New York: World Bank; 2021 (<https://www.worldbank.org/en/country/tajikistan/overview#1>, accessed 23 March 2021).

Fig. 9. Government health expenditure per capita



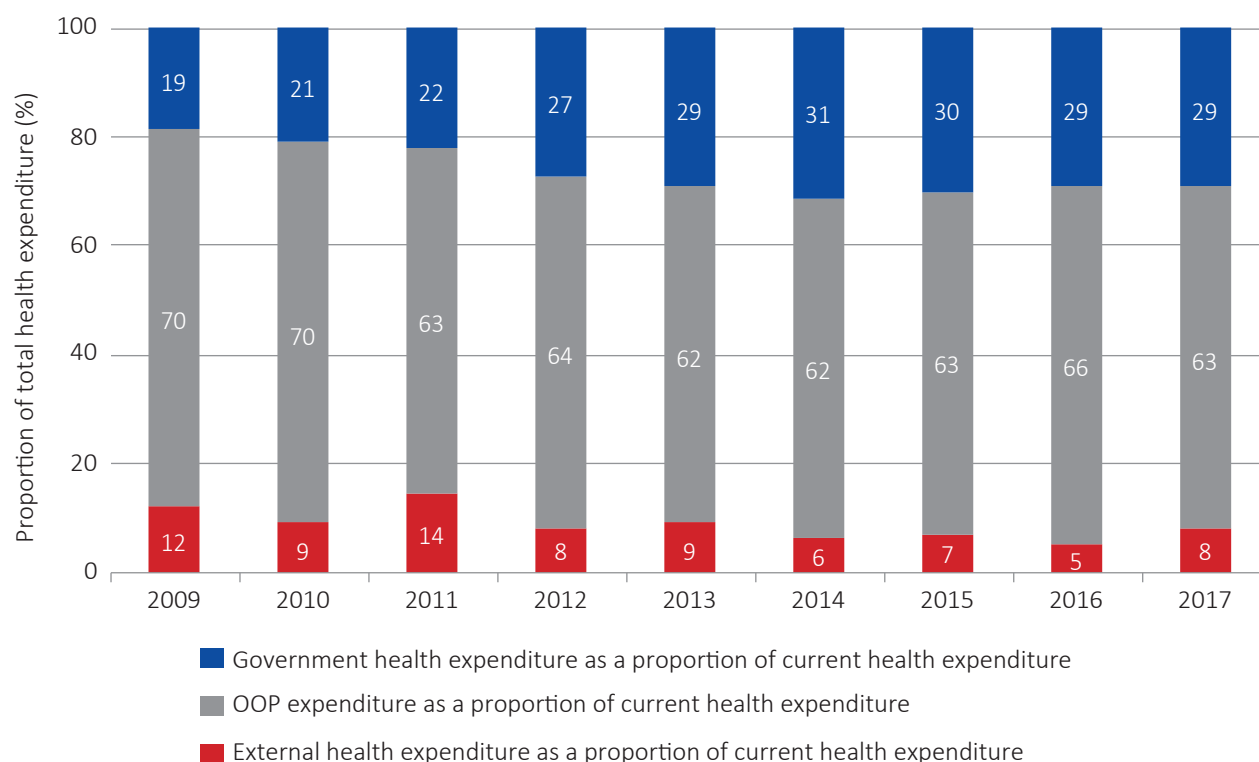
Source: World Bank Development Indicators [online database]. Washington DC: World Bank Group; 2020 (<https://databank.worldbank.org/source/world-development-indicators/preview/on#>, accessed 11 March 2020).

In close collaboration with international partners, the Ministry of Health and Social Protection of Tajikistan is working on a national programme of strategic development of health care and social protection for 2021–2030. The main goal of the new strategy is to reduce inequities and enhance social justice by ensuring equal access to health and social care. National consultations were still in progress at the time of writing. The strategy is expected to be finalized by the end of next year.

Tajikistan's health care system faces numerous challenges. First, OOP payments prevent many patients from accessing the health care services they need (Fig. 10). The country has one of the highest OOP rates in the WHO European Region,⁵ and these payments disproportionately affect the poor.

⁵ Khodjamurodov G, Sodiqova D, Akkazieva B, Rechel B. Tajikistan: health system review. *Health Syst Transit*. 2016;18(1):1–114.

Fig. 10. External, OOP and government health expenditure as proportions of current health expenditure



Source: WHO Global Health Expenditure Database [online database]. Geneva: World Health Organization; 2019 (<https://apps.who.int/nha/database/ViewData/Indicators/en>, accessed 11 March 2020).

Other challenges include inequities between rural and urban areas and fragmentation of services and approaches. PHC is funded on a per capita basis, at different reimbursement rates for urban and rural settings: US\$ 5.8 per capita at urban facilities, US\$ 4.6 per capita at rural facilities and US\$ 2 capita at remote facilities. An initial pilot project began in 2007, and various pilots with the same objectives have been implemented in the ensuing years. In addition, results-based financing has been piloted in 10 districts of the Sogd and Khatlon regions and Faizabad district since 2013.

While the country reports that a strategy for UHC is in place, no UHC programme has yet been implemented. Financing of the health care system remains largely input-based,⁶ fragmented and inefficient. The way health service provision is currently financed increases inequity in access and inefficiency in spending of the scarce available resources.

Government Decree No. 600

One of the main legal documents regulating the provision of health care services is Decree No. 600 of the Government of Tajikistan of 2 December 2008. This describes types of services and population groups entitled to these services free of charge. Access requires a referral from the family doctor, district therapist (or general practitioner), obstetrician/gynaecologist, paediatrician or district health commission. Services are provided to vulnerable groups as defined by the social security programme:

- participants in the Second World War;
- heroes of the Republic of Tajikistan, Soviet Union and those who have been awarded the Order of Glory (all three levels);
- heroes of socialist labour;

⁶ Ensor T, Langenbrunner J. Allocating resources and paying providers. In: McKee M, Healy J, Falkingham J, editors. Health care in central Asia. Buckingham: Open University Press; 2002:108–24.

- war veterans, participants in international conflicts;
- citizens affected by the Chernobyl accident and members of their family left without guardianship;
- people with disabilities injured while performing military service;
- people who have been disabled since childhood;
- disabled children under the age of 18 years;
- orphans living in state orphanages, family orphanages (foster families) boarding schools for orphans, children left without parental care;
- children under the age of 1 year;
- disabled people included in population group I (according to social status) and population group II (according to health status) due to labour injury, professional or general illness;
- members of poor families and poor single citizens;
- citizens aged 80 years and older;
- citizens living in nursing homes and boarding schools.

According to Decree No. 600, the services provided include:

- emergency medical care;
- PHC services;
- specialized outpatient medical care;
- provision of drugs, vaccines and laboratory tests at the PHC level;
- inpatient/hospital medical care;
- dental care;
- sanitary (including epidemiological) and hygienic measures.

SRMNCAH services included in Decree No. 600 include monitoring of children under 5 years and dispenserization of schoolchildren. According to the decree, delivery in hospitals is covered for women who are registered during pregnancy and attend antenatal care regularly.

Basic benefit package

A basic benefit package (BBP) was introduced in 2014 as a pilot in the Sogd region, followed by the Khatlon region in early 2015.⁷ To address underfunding, formalize payments and strengthen PHC, co-payments or user fees were introduced. These include co-payment regulations and BBP reforms piloted in eight districts (Dangara, Spitamen, Tursunzade, Rasht, Shahrinav, Varzob and Sarband districts and Nurek city).

The BBP guarantees a defined set of health services at no official charge for a limited number of population groups and patient categories (Table 2). For all others, between 50% and 100% of co-payments are mandated for ambulatory and diagnostics services, depending on availability of a referral from a PHC doctor (50%) and place of residence (80% for residents of the district where care is sought; 100% for non-residents).

⁷ Jacobs E. The politics of the basic benefit package health reforms in Tajikistan. Glob Health Res Policy. 2019;4:14. doi:10.1186/s41256-019-0104-4.

Table 2. Population groups and patient categories exempted from co-payments under the BBP in pilot districts

Group I – by social status	Group II – by health status
Participants in the Second World War	Children under 5 years with acute respiratory infections and diarrheal diseases, as part of the IMCI programme
Heroes of the Republic of Tajikistan, Soviet Union and those who have been awarded the Order of Glory (all three levels)	Patients with haemophilia
Heroes of socialist labour	Patients with leprosy
War veterans, participants in international conflicts	Patients with rabies
Citizens affected by the Chernobyl accident and members of their family left without guardianship	Patients with diphtheria
People with disabilities injured while performing military service	Patients with tuberculosis (within the framework of the directly observed treatment, short-course programme of tuberculosis management)
People who have been disabled since childhood	AIDS patients (acquired immunodeficiency syndrome)
Disabled children under the age of 18 years	Patients with diabetes mellitus (insulin-dependent form)
Orphans living in state orphanages, family orphanages (foster families) boarding schools for orphans, children left without parental care	
Children under the age of 1 year	
Disabled people included in groups I and II due to labour injury, professional or general illness	
Members of poor families and poor single citizens	
Citizens aged 80 years and older	
Citizens living in nursing homes and boarding schools	

Source: Decree No. 90 of the Government of Tajikistan of 25 February 2017.

SRMNCAH services provided within the context of the BBP are very limited and not clearly defined.⁸ According to the terms of the BBP, pregnant women who are registered and attend regular check-ups are entitled to the following services without additional payment:

- blood test (twice during pregnancy)
- haemoglobin test (twice during pregnancy)
- Wassermann reaction test (twice during pregnancy)
- HIV test (twice during pregnancy)
- urine test (twice during pregnancy)
- proteinuria test (twice during pregnancy)
- urine bacteriological test (if required)
- vaginal smear test (twice during pregnancy)
- ultrasound investigation (twice during pregnancy).

⁸ Ministry of Health and Social Protection of Tajikistan, UNICEF. Technical assistance to the Ministry of Health and Social Protection in defining and costing the minimum reproductive, maternal, newborn, child and adolescent health service package: final report. Dushanbe: United Nations Children's Fund; 2018.

In addition, those who attend at least four antenatal care visits during the pregnancy are entitled to hospital delivery without cost. All others have to co-pay according to the regulation.

Hospital care financing in Tajikistan is input-based. Overall, it is difficult to assess who is entitled to what. Numerous “pilots” implemented in the country do not guarantee equity in access to health care services. High OOP payments undermine financial protection and constitute a barrier for the population to access health care services when needed.

Ministry of Health and Social Protection representatives and other stakeholders interviewed during the assessment acknowledged deficiencies in financing for the provision of SRMNCAH services. In April 2018 UNICEF assisted the Ministry in defining the minimum service package for SRMNCAH services. The report states that 92 services are required to be added to provide a minimum SRMNCAH service package:

- reproductive health – 22 services
- maternal health – 27 services
- newborn health – 12 services
- child health – 19 services
- newborn nutrition – 8 services
- adolescent health – 4 services.

Key informants reported that even for the services that are officially provided free of charge according to policy, patients have to pay – either officially or “under the table”.

The country is reportedly in the process of developing a new health strategy aiming to strengthen PHC by defining a BBP that will be provided equally to the entire population.

Table 3 sets out a summary of findings on health care financing policies.

Table 3. Summary of findings on health care financing policies

Attribute	Rating	Criteria for rating
UHC	Considerable need for improvement	Currently, Tajikistan has no UHC programme. The country is planning to introduce a social insurance programme in 2022 and to establish a state health insurance fund, pooling all financial resources for health. The fund is planned to function as single payer for health care services included in the BBP. This is expected to decrease inefficiencies and duplications in service provision and lead to more efficient use of available resources.
Financial protection	Considerable need for improvement	OOP payments are high (63% in 2017): this is the highest rate among eastern European and central Asian countries and does not facilitate equitable access for all citizens.

Table 3. (contd)

Attribute	Rating	Criteria for rating
Financing mechanisms for PHC	Considerable need for improvement	Financing of PHC is fragmented. Two different “pilots” are testing funding mechanisms: in 10 districts results-based financing has been piloted with support from the World Bank. In all other facilities per capita funding has been introduced at different reimbursement rates for urban and rural settings: US\$ 5.8 per capita at urban facilities, US\$ 4.6 per capita at rural facilities and US\$ 2 per capita at remote facilities.
Financing mechanisms for hospital care	Considerable need for improvement	Hospital funding is mainly input-based. Despite several attempts to reduce the number of beds, the hospital network still seems to have overcapacity and to be underutilized.

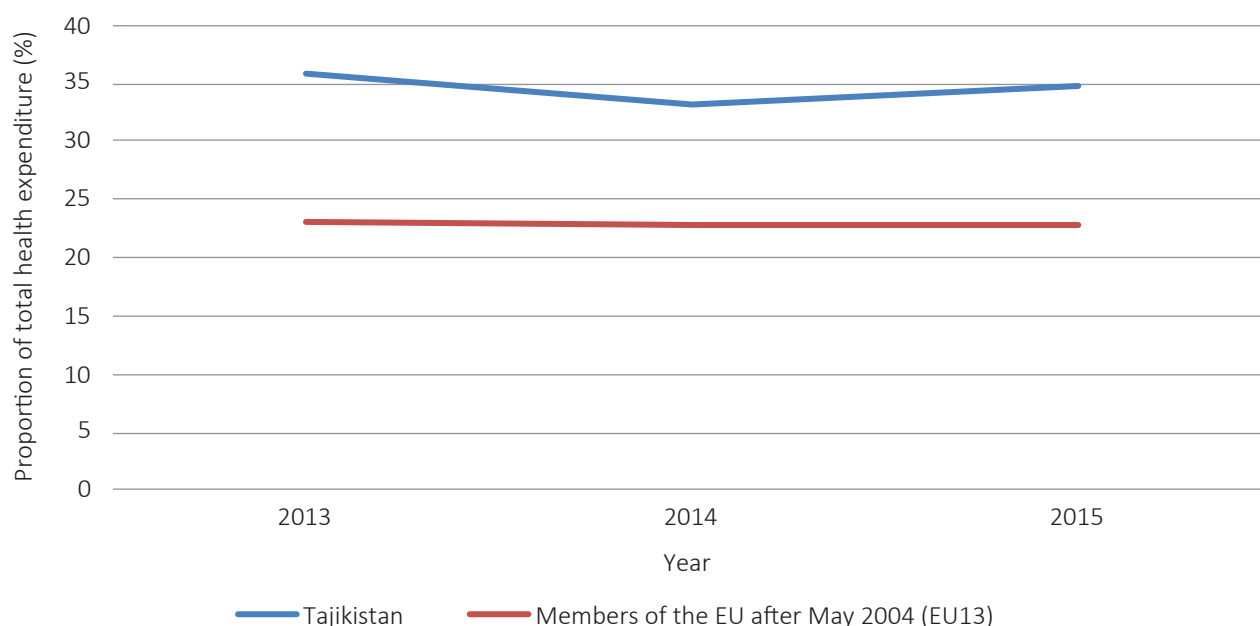
Essential medicines and medical products for SRMNCAH

Of Tajikistan’s total health expenditure, 34.7% is spent on pharmaceuticals; this is much higher than the average in the WHO European Region (Fig. 11). There are several reasons for this.

- Very few pharmaceuticals are provided under the BBP.
- Polypharmacy is frequent.
- Prices for pharmaceuticals are very high.

According to the Programme of State-guaranteed Health Services 2017–2019, the state provides some drugs for children under the IMCI and vaccination programmes. No other drugs required for SRMNCAH services are covered. Folic acid is not provided for pregnant women. While in some districts iron is provided, this is not the general practice throughout the country. Contraceptives are provided by the United Nations Population Fund, but supply was due to stop in 2020 and there are no plans to continue supply through the government.

Fig. 11. Total pharmaceutical expenditure as a proportion of total health expenditure



Source: European Health for All database (HFA-DB). In: European Health Information Gateway [online database]. Copenhagen: WHO Regional Office for Europe; 2020 (https://gateway.euro.who.int/en/indicators/hfa_578-6770-total-pharmaceutical-expenditure-as-of-total-health-expenditure/), accessed 11 March 2020.

No recent surveys could be found regarding the current situation of availability and affordability of drugs in Tajikistan. The most recent information available is from the 2014 household survey conducted in eight districts, which specifically looked at drug prescription patterns at the PHC level.⁹

The 2014 survey found that 80.1% of patients received a drug prescription after visiting a PHC facility. The median number of drugs prescribed was three (ranging from one to eight); the median number of drugs procured by patients was three. In 31% of cases the prescription included injectables. While 94.5% of patients were able to procure at least some of the drugs prescribed by the family doctors, 5.5% reported not being able to procure any of the drugs on the prescription. Reasons given included geographical access to pharmacies, financial resources and stock-outs of drugs. Only 1.5% of the respondents reported having received drugs free of charge at or through the PHC facility.

Delivery and safety of SRMNCAH services

Many of the key diagnostic tests for SRMNCAH are currently not available at the PHC level but require referral to a laboratory; for example, no urine dip sticks are available, blood for haemoglobin testing needs to be drawn in a laboratory and so on. All laboratories across the country are private and thus require the patient to pay out of pocket.

Vaccination takes place at the PHC level and is reportedly carried out by specific vaccination-only staff. Screening for cervical cancer and STIs is not available at the PHC level.

⁹ Donadel M, Karimova G, Nabiev R, Wyss K. Drug prescribing patterns at primary health care level and related out-of-pocket expenditures in Tajikistan. BMC Health Serv Res. 2016;16(1):556. doi:10.1186/s12913-016-1799-2.

The current method of health system funding does not encourage investment in comprehensive universal PHC. Given that providers rely on informal payments to supplement their salaries, incentive systems do not encourage them to provide evidence-based care and ensure equitable coverage for patients from different socioeconomic groups; rather they concentrate on patients' ability to pay.

The responsibilities of the family doctor include a variety of services, but they rarely provide all of these as the service delivery structure is fragmented. At the PHC level, multiple referrals were made for diagnostic tests, administering vaccinations, inserting and providing contraceptives and other family planning services.

In some cases, patients go directly to hospitals rather than PHC facilities, or attend private clinics. Key informants also reported high OOP payments for drugs and transportation. No national network of emergency transport is in place across the country.

At the same time, a considerable amount of funding is made available by the government for mandatory premarital screening, which include tests for HIV, hepatitis B and C and genetic diseases.

Health workforce for SRMNCAH

Tajikistan suffers from severe brain drain (high rates of skilled personnel migrating from the country), especially among the health workforce. In Dushanbe, the capital, the government closed the paediatric faculty in the university as fewer students were applying to train as paediatricians. Low salary was one of the main causes, and many people moved to study in the Russian Federation. Due to the perceived shortage, physicians from other areas have been re-purposed to provide care as paediatricians. As a result, to give one example, neurologists who have not specialized in child health provide care for children and adolescents. Doctors retrained to provide other services may lack confidence in delivering essential SRMNCAH services, causing multiple referrals and fragmentation of services.

Low salaries of health workers have led to the need for informal payments and additional income generation. Table 4 shows the gross average salaries of the health workforce compared to other work areas within Tajikistan, as reported by key informants.

Table 4. Comparison of gross average salaries in the health and other sectors

Profession	Salary (US dollars/month)
PHC physician in the capital	85–125
PHC physician in a rural area	62–84
Nurse	42–50
Education worker	90–180
Bus driver	100–200

Source: data reported by key informants during the assessment.

Health worker shortages versus health worker utilization

While staff shortages were mentioned by several key informants, most doctors interviewed had seen between two and four patients that day. Doctors reported seeing on average four or five patients a day (most saw between zero and 12 patients a day; only one doctor reported seeing up to 30).

The number of paediatricians per 100 000 population in Tajikistan is above the average for the WHO European Region (22 versus a regional average of 19). Numbers of general practitioners/family doctors were not available, and the number of nurses was below average (391 versus a regional average of 691 per 100 000 population).

While some rural areas may have shortages of doctors, nurses and midwives, in the areas visited the assessment found high doctor:patient ratios. Many different specialists work at the PHC level, including vaccination specialists who are only responsible for vaccinating children, and heads of reproductive health centres, HIV centres, healthy lifestyle centres, IMCI centres and so on.

Private sector

Tajikistan has about 400 private clinics, and people are reported to like the services provided in these. During pregnancy, women visit private clinics in addition to the PHC facilities to receive additional services. Parents also reported that they prefer bringing their children to private clinics.

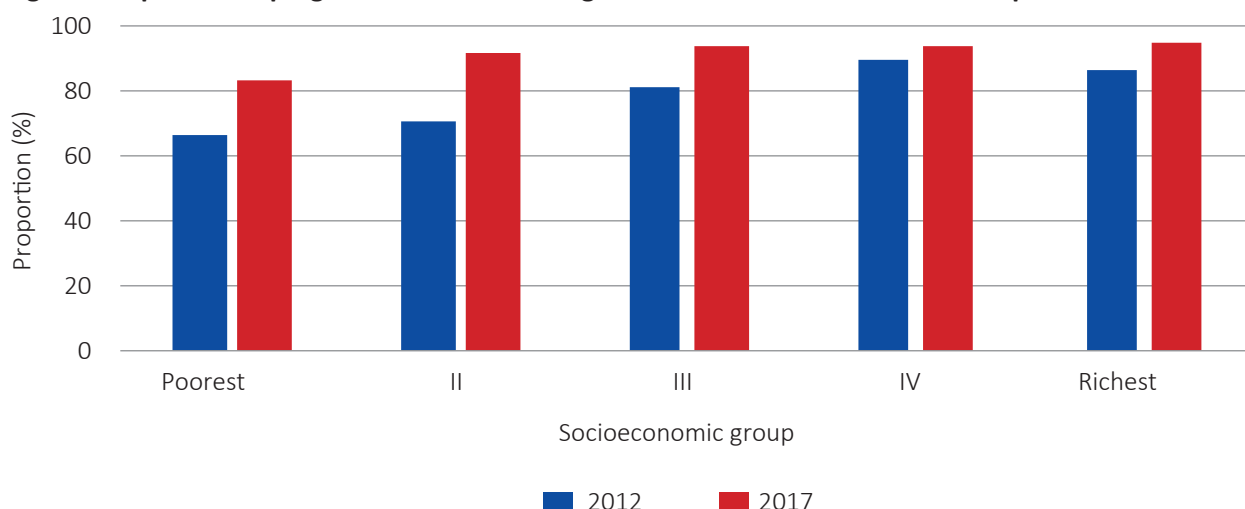
Tracer services

Antenatal care: pre-eclampsia

The country has 43 standards and protocols for antenatal care and pregnancy complications, including one for pre-eclampsia; these are reported to be adapted from WHO guidelines. According to key informants, however, implementation of the protocols is often hindered due to lacks of funding, resources and capacity of health workers.

All pregnant women are registered at health facilities and are advised to come in for check-ups. Family doctors and nurses allocate half of their time to home visits for those who are not able to attend the health facilities in person. They try to follow up with the population of pregnant women for whom they are responsible and to make sure that women deliver with skilled birth attendants, including for home deliveries (Fig. 12). A significant proportion of deliveries take place at home.

Fig. 12. Proportion of pregnant women receiving antenatal care from a skilled care provider



Sources: Tajikistan: Demographic and Health Survey 2012. Dushanbe: Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health and Social Protection and ICF; 2013 (<https://dhsprogram.com/publications/publication-FR279-DHS-Final-Reports.cfm>); Tajikistan: Demographic and Health Survey 2017. Dushanbe: Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health and Social Protection and ICF; 2018 (<https://dhsprogram.com/publications/publication-FR341-DHS-Final-Reports.cfm>).

Pre-eclampsia is estimated to affect 2–8% of all births. While prevalence data for pre-eclampsia were not available to the assessment team, key informants at the ministry level confirmed that pre-eclampsia is very common in Tajikistan.

At PHC facilities and health houses (the first point of contact in rural areas) where pregnant women are routinely tracked, providers often stated that no or very few cases of pre-eclampsia had been diagnosed in recent years. Of the nine PHC facilities, district hospitals and rural health houses, six had seen no cases of pre-eclampsia in recent years. This points to problems with the detection of pre-eclampsia, which indicates issues with the quality of antenatal care provided. This finding was corroborated by key informants at the referral level, who stated that women with pre-eclampsia arrive late and without proper management, indicating problems with health workers' skills at the PHC level.

Key informants identified a lack of equipment (such as urine analysis/test strips) and a lack of knowledge and skills of primary care providers to detect and manage the condition as causes for these findings. Maternal mortality in Tajikistan is one of the highest in the WHO European Region, and pre-eclampsia/eclampsia is among the three leading causes of maternal death. Improvements in early identification at the PHC level, timely referral and proper management could prevent a significant proportion of maternal deaths.

Findings beyond pre-eclampsia

Breastfeeding seemed to be relatively well practised in Tajikistan. Women are advised to initiate breastfeeding right after birth. In the facilities visited, all women who had just given birth were breastfeeding (Table 5).

Table 5. Breastfeeding indicators

Indicator	Proportion (%)	Year
Infants who were breastfed within the first hour ^a	49.6	2012
Infants aged less than 6 months who are fed exclusively with breast milk ^a	35.8	2017
Proportion of infants breastfed at three months ^b	83	2013
Proportion of infants breastfed at six months ^b	92	2015

Sources:

^a The Global Health Observatory [online database]. Geneva: World Health Organization; 2021 (<https://www.who.int/data/gho/data/indicators/>);

^b European Health for all Database (HFA-DB). In: European Health Information Gateway [online database]. Copenhagen: WHO Regional Office for Europe; 2015 (<https://gateway.euro.who.int/en/datasets/european-health-for-all-database/>). Accessed 7 April 2021.

Pregnant women are eligible for free iron supplements and are also entitled to receive free dental services such as preventive check-ups. Due to the lack of funds, however, coverage of these supplements is very low, and most women have to pay out of pocket to receive the supplements and services.

All pregnant women are tested for HIV, tuberculosis and syphilis, and are eligible for five ultrasound examinations at no cost to the patient. Again, due to the lack of funding, women are mostly provided with only two cost-free ultrasound examinations. Key informants confirmed that women who want additional ultrasound examinations go to private institutions.

Abortion is legally allowed in Tajikistan (Table 6). Prescriptions are needed for medically induced abortions, and most are conducted through vacuum aspiration. Abortion is not done at the PHC level: all women are referred to hospitals.

Table 6. Abortions, absolute number and rates, by age

Age (years)	Proportion of women with an induced abortion (%)	Number of women interviewed in the Demographic and Health Survey (DHS)	Number of women with an induced abortion
<20	0.2	2013	3
20–24	2.1	1950	42
25–34	9.6	2797	269
35+	21.0	2896	608

Sources: Tajikistan: Demographic and Health Survey 2012. Dushanbe: Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health and Social Protection and ICF; 2013 (<https://dhsprogram.com/publications/publication-FR279-DHS-Final-Reports.cfm>); Tajikistan: Demographic and Health Survey 2017. Dushanbe: Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health and Social Protection and ICF; 2018 (<https://dhsprogram.com/publications/publication-FR341-DHS-Final-Reports.cfm>).

Table 7 sets out a summary of the findings in relations to antenatal care.

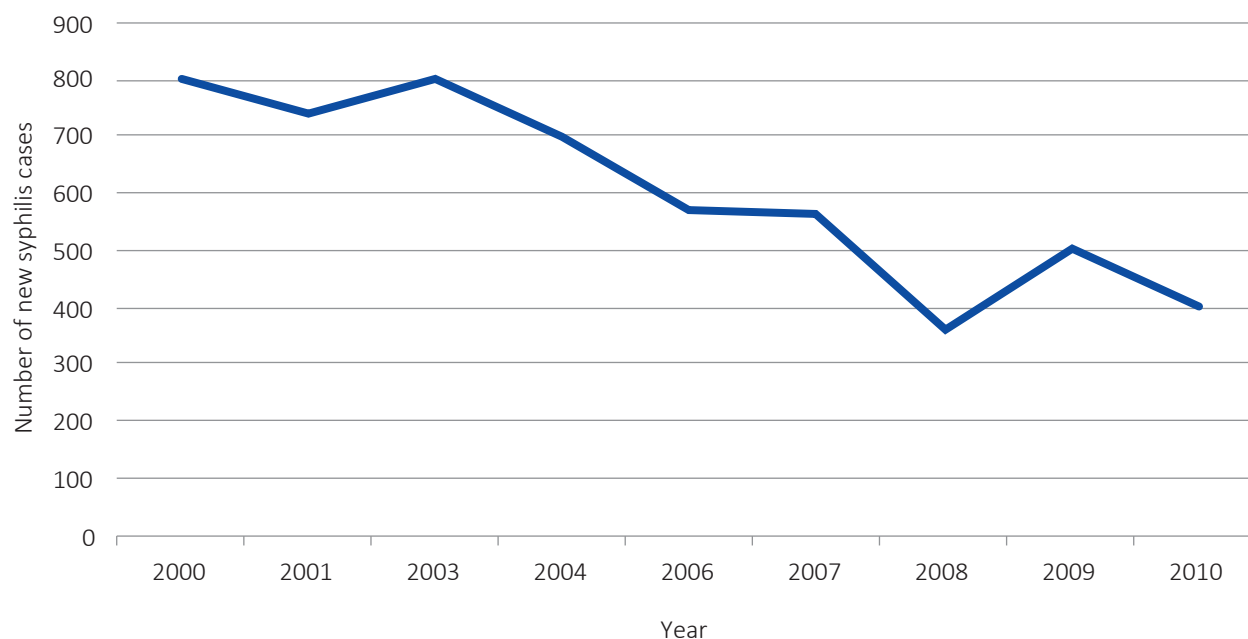
Table 7. Summary of findings on antenatal care: management of pre-eclampsia

Attribute	Rating	Considerations for rating
Protocols and legislation	Good practice/ little need for improvement	Tajikistan has 43 standards and protocols for antenatal care and pregnancy complications, including one for pre-eclampsia; these are reported to be adapted from WHO guidelines.
Scope of services	Some need for improvement	WHO-recommended antenatal care interventions are included in the protocol, but in reality they are not available to the population.
Population coverage and/or access	Some need for improvement	Women are required to pay out of pocket for antenatal care services due to scarcity of resources. Women seek services in the private sector as they are not sufficiently available in the public sector.
Quality of services	Some need for improvement	Providers at different levels lack appropriate knowledge and skills for routine care and management of complications. Essential equipment is not available.

STIs (excluding HIV)

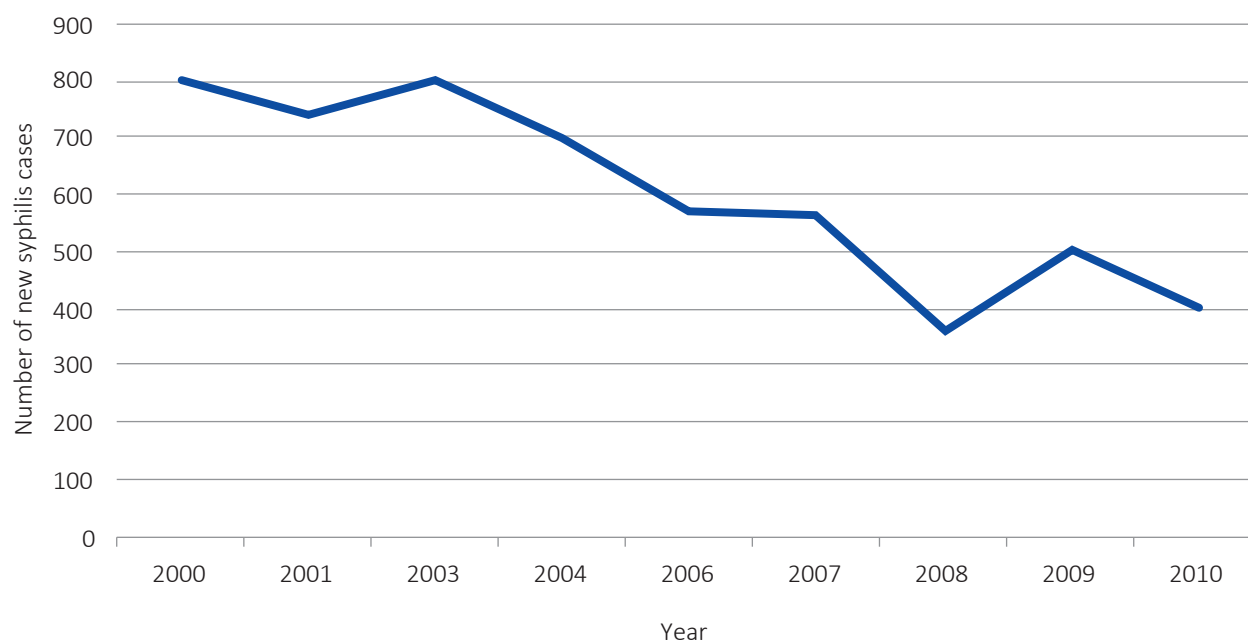
According to key informants, incidence of STIs such as syphilis and gonorrhoea has decreased overall in recent years. The decreasing status of syphilis cases could be seen up to 2010, but recent data could not be obtained to verify the decrease (Fig. 13 and Fig. 14).

Fig. 13. Syphilis cases (all types) over time



Source: European Health for All database (HFA-DB). In: European Health Information Gateway [online database]. Copenhagen: WHO Regional Office for Europe; 2020 (https://gateway.euro.who.int/en/indicators/hfa_320-2050-incidence-of-syphilis-per-100-000/, accessed 11 March 2020).

Fig. 14. Syphilis incidence per 100 000 population over time



Note: data for 2002 and 2005 were unavailable.

Source: European Health for All database (HFA-DB). In: European Health Information Gateway [online database]. Copenhagen: WHO Regional Office for Europe; 2020 (https://gateway.euro.who.int/en/indicators/hfa_320-2050-incidence-of-syphilis-per-100-000/, accessed 11 March 2020).

Most key informants interviewed stated that they rarely see patients with STI symptoms and that if they did, they would refer them to the hospital. In the light of advances in rapid tests moving towards testing and treatment at the point of care, the assessment revealed deficiencies in availability of STI services at the PHC level, leading to multiple referrals and fragmentation. HIV, syphilis, gonorrhoea and other STIs are diagnosed at the PHC level in urban facilities, but receiving any type of diagnosis regarding STIs is not available in rural areas.

Although everyone is provided with free HIV tests and is eligible for syphilis tests, in some districts even first-level hospitals do not have the resources to manage STIs but have to refer patients. All laboratories across the country are privately run for profit, and patients are required to pay for testing. Medicines for the management of STIs are not covered by the government, and prescribed treatments need to be purchased by the patient at a pharmacy. These findings point to a lack of services at the PHC and referral level, and a need for OOP expenditure for diagnosis and treatment.

Table 8 sets out a summary of the assessment's findings on STIs.

Table 8. Summary of findings on STIs

Attribute	Rating	Considerations for rating
Protocols and legislation	Considerable need for improvement	Protocols do not seem to be available.
Scope of services	Considerable need for improvement	Referral for laboratory testing is required in many settings. All laboratories across the country are privately run for profit, and patients have to pay for services out of pocket.
Population coverage and/or access	Considerable need for improvement	Services are not available at the PHC level and referrals to hospitals, sometimes even beyond the district hospital, are required.
Quality of services	Considerable need for improvement	Stigma seems to limit the availability of data and services. Treatment available in PHC seems to be inconsistent; (self-)referral to specialists and/or hospitals seems to be common; and prices incurred by patients are not transparent.

Neonatal transport

Neonatal transport is a critical phase of perinatal care, requiring a specialist team and equipment to ensure maximum safety and efficiency in provision of care for sick neonates. In Tajikistan neonatal transport often has to be organized privately by parents/family as the number of emergency vehicles is insufficient. According to key informants at the ministry level, less than 20% of the country is covered by ambulance services.

Those vehicles that do exist and are used for neonatal transport are often not equipped properly, and the capacity of members of transport teams is reportedly limited. No helicopters are available for emergency transport. If a newborn requires referral to a tertiary care facility, a standard ambulance is usually provided by the hospital that is referring, but these ambulances are not equipped specifically for the transport of newborns: they do not have incubators and similar. Only two ambulances across the country are equipped for neonatal transport (one is stationed in Dushanbe; one ambulance funded by the German development agency Deutsche Gesellschaft für Internationale Zusammenarbeit is stationed in Khulob district). Most of the time, parents are asked to take their newborn using any means of transport, self-organized and self-paid.

With a significant proportion of deliveries taking place at home, swift transport mechanisms in case of emergencies are particularly important to save lives. Specific data monitoring transfer times and status of the neonates arriving are not collected, however, as no clear guideline on the assessment of neonates is in place. These findings point to a lack of a mechanism for primary stabilization of sick neonates, referrals, equipment and capacity for neonatal transport. Key informants reported that an algorithm for improving neonatal transport exists but has not yet been implemented owing to a lack of funding.

Table 9 sets out a summary of the assessment's findings on neonatal transport.

Table 9. Summary of findings on neonatal transport

Attribute	Rating	Considerations for rating
Protocols and legislation	Considerable need for improvement	Standards reportedly exist, but while algorithms for neonatal transportation have reportedly been developed, they have not been approved by the Ministry of Health and Social Protection.
Scope of services	Considerable need for improvement	Standards are not implemented. More than 70% of transports are reportedly organized privately by parents/families. No systematic mechanism exists for adequate transport of neonates.
Population coverage and/or access	Considerable need for improvement	Coverage is limited (reportedly 20% of the country), and transport is often organized by patients or informally by providers. Costs have to be covered out of pocket by patients. Only two vehicles specifically equipped for neonatal transport are available in the entire country.
Quality of services	Considerable need for improvement	No data are collected. Key informants reported a lack of equipment and skilled providers.

Case management of common childhood conditions: cough and pneumonia

Pneumonia incidence and prevalence rates disaggregated by age were not available to the assessment team. Hospitalization rates for children with respiratory tract infection or pneumonia and overall hospitalization rates by age are reportedly available according to key informants at the Ministry of Health and Social Protection, but these could not be obtained by the assessment team, despite several attempts.

Key informants frequently mentioned use of WHO's IMCI strategy. Many health professionals and the key informants at the ministry level are familiar with the strategy and are trained to provide health care according to the IMCI clinical guidelines. In practice, however, IMCI guidelines were not followed.

According to key informants, the most frequent complaint of children presenting at polyclinics is viral respiratory tract infections. Doctors carry out home visits if required.

During the hospital ward visits there seemed to be excess bed capacity, as wards were predominantly empty. According to the statistics provided by the Ministry of Health and Social Protection, there are 40 060 beds for 9.3 million people, or 43 beds/10 000 population. In 2010 there were 38 167 beds, but the bed coverage per 10 000 population was 50.1; the rate was 44.9 per 10 000 population in 2017. The utilization rate of hospital beds was 71.2% in 2010 and decreased to 66.4% in 2017.

The data from statistics on hospital bed utilization presented to the team and data gathered during ward visits were contradictory, leading to a likelihood of over-hospitalization in some health facilities and unnecessary bed capacity in others. The hospitalization rate in Tajikistan was 10.9 per 100 000 people in 2017.¹⁰ These numbers are inconsistent and need to be reviewed by the WHO Country Office and Ministry of Health and Social Protection.

¹⁰ солимии Ахлӣ ва фаъолияти муассисаҳои тандурустӣ дар соли [Public health and the activities of health facilities in the year]. Dushanbe: Tajikistan Government Statistics; 2018.

According to key informants, the duration of hospital stay for pneumonia cases is about 5– 10 days. Parents are allowed to stay if the child is below 14 years old, but are only allowed to be with them according to the severity of the child’s condition for those above 14 years.

Treatment prescribed is often not evidence-based and not in line with international guidelines, but includes medication with unclear benefits, such as interferon therapy, intramuscular or intravenous vitamin injections and antihistamines for viral cough. Prescribed medications must be purchased in private pharmacies and paid for by the parent after the child reaches 1 year of age, regardless of whether the patient is treated as an inpatient or outpatient. Non-evidence-based practices of prescribing unnecessary medication contribute to the high share of OOP payments.

A regulation has been put in place aiming to reduce polypharmacy, which restricts doctors to prescribing a maximum of five drugs at a time. It seems, however, that prescribing of multiple and invasive drugs remains prevalent.

Table 10 sets out a summary of the findings on case management of common childhood conditions.

Table 10. Summary of findings on case management of cough/pneumonia

Attribute	Rating	Considerations for rating
Protocols and legislation	Good practice/ little need for improvement	IMCI and the WHO Pocket Book of Hospital Care for Children have been introduced.
Scope of services	Some need for improvement	Services provided are not in line with available standard treatment guidelines.
Population coverage and/or access	Some need for improvement	Parents incur formal costs for children aged over 1 year for drugs, lab tests and similar. Non-evidence-based treatment for cough/pneumonia leads to additional OOP expenditure.
Quality of services	Considerable need for improvement	Polypharmacy and overuse of antibiotics are prevalent. Use of unnecessary invasive treatments (such as intramuscular injections) and hospitalization of cases that could be safely managed as outpatient are both results of health provider practice and parent expectation. There is therefore a risk of antimicrobial resistance, with detrimental effects on individuals and society.

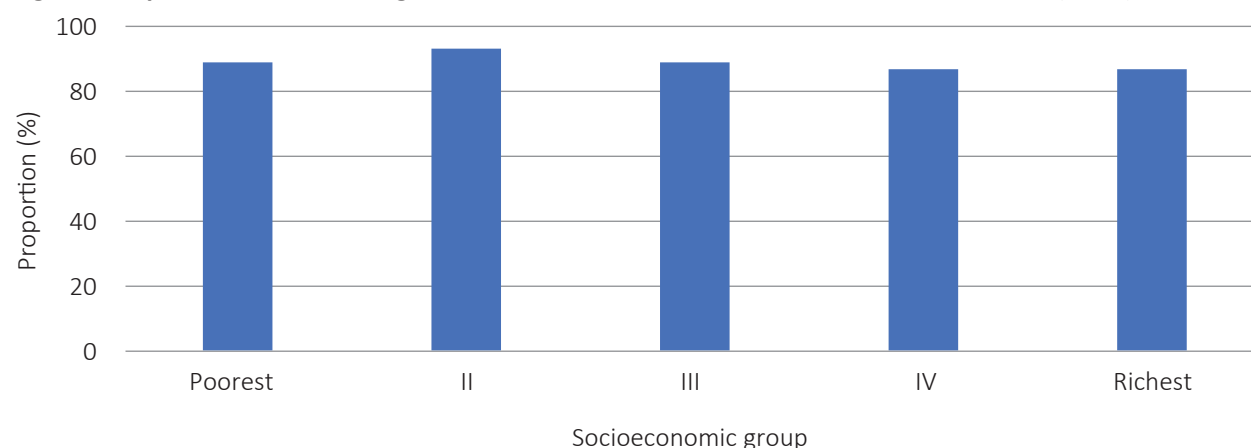
Immunization

Vaccination coverage is reportedly high, while the 2017 DHS reported coverage of 82%. Vaccinations are administered according to the national vaccination schedule. Table 11, Fig. 15 and Fig. 16 show coverage rates for different vaccinations in Tajikistan.

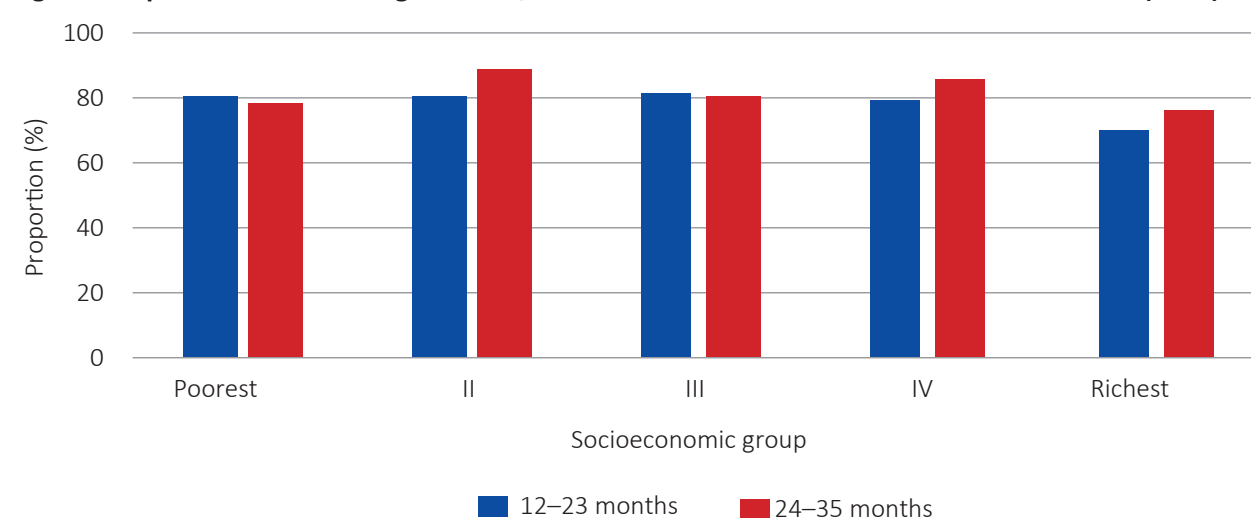
Table 11. Summary of findings on vaccination coverage

Vaccine	Definition of indicator	Value (%)	Year
Diphtheria, tetanus and pertussis	Diphtheria tetanus toxoid and pertussis (three doses) immunization coverage among 1-year-olds	96	2018
Measles	Proportion of children who received the first dose of measles containing vaccine	98	2018
Pneumococcal conjugate vaccine (PCV)	Proportion of infants who received the third dose of pneumococcal conjugate vaccine	N/A	N/A
Rotavirus	Proportion of infants who received the last dose of rotavirus vaccine (second or third dose, depending on vaccine used)	96	2018
Human papillomavirus (HPV)	Proportion of live births to adolescent women per 1000 women	N/A	N/A

Source: Tajikistan: WHO and UNICEF estimates of immunization coverage: 2019 revision. Geneva: World Health Organization; 2020 (https://www.who.int/immunization/monitoring_surveillance/data/tjk.pdf).

Fig. 15. Proportion of children aged 18–29 months who received all basic vaccinations (2012)

Source: Tajikistan: Demographic and Health Survey 2012. Dushanbe: Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health and Social Protection and ICF; 2013 (<https://dhsprogram.com/publications/publication-FR279-DHS-Final-Reports.cfm>).

Fig. 16. Proportion of children aged 12–23/24–35 months who received all basic vaccinations (2017)

Source: Tajikistan: Demographic and Health Survey 2017. Dushanbe: Statistical Agency under the President of the Republic of Tajikistan, Ministry of Health and Social Protection and ICF; 2018 (<https://dhsprogram.com/publications/publication-FR341-DHS-Final-Reports.cfm>).

Vaccine supplies are mostly procured through UNICEF Supply Division and funded by Gavi, the Vaccine Alliance. According to key informants at the ministry level, in 2019 the government made available US\$ 1 million for vaccinations. PCV and HPV vaccines have not been introduced yet, but the government is reportedly keen on including these in the national vaccine programme and is looking to Gavi for support.

Supply chains are reportedly working well, although key informants reported delays during the winter months.

Informants at the PHC level in urban areas reported that vaccinations are administered almost every day. In rural areas, intervals for up to four months are common, mainly due to a shortage of vaccine stocks, as well as the number of newborns in rural areas. As one vial of Bacillus Calmette–Guérin vaccine contains dosages for 20 children, health workers will wait until there are about 15 newborns to receive the vaccination.

Children have to be seen by a doctor before being vaccinated. After receiving the shot, children are observed in the facility for 30 minutes to observe whether complications occur. Although it is not national policy, many health workers also visit homes after three days to check on the child after receiving a vaccination. This leads to inefficiency in work for the health workers, as many have to walk by foot to visit each household, and the households are often very distant.

According to key informants, vaccine hesitancy has decreased. When rare cases occur, health workers actively engage to persuade households to get vaccinated. Tajikistan was set to be announced as a measles-free country in 2020.

Table 12 sets out a summary of the assessment’s findings on immunization.

Table 12. Summary of findings on immunization

Attribute	Rating	Considerations for rating
Protocols and legislation	Some need for improvement	The national immunization schedule is in line with WHO’s Expanded Programme on Immunization, but it does not include vaccination with HPV and PCV.
Scope of services	Some need for improvement	HPV and PCV are not available.
Population coverage and/or access	Some need for improvement	Vaccine coverage is high, and creative efforts are made to reach hesitant parents.
Quality of services	Some need for improvement	Contraindications are not always evidence-based.

Adolescent-friendly sexual and reproductive health services

Adolescent birth rates

Adolescent birth rates are high in Tajikistan: of 1000 girls aged 15–19 years, 54 give birth (Table 13). The country has made efforts to provide and increase adolescent-friendly health services: 21 adolescent health centres have been established in municipalities and districts in the country, with UNICEF support. The centres are supposed to provide counselling, provision of contraceptives and STI diagnostic tests. The age of consent for accessing medical services at these health care centres is 18 years, however: without parental consent, health care providers are not allowed to provide services to adolescents. While in most cases parental involvement would be beneficial for the adolescent, in certain circumstances it can be detrimental to their health and well-being, particularly when concerning sexual and reproductive health. In fact, if a pregnant girl turns to the adolescent-friendly health centres for help, law enforcement is called if she is younger than 16 years, and parents are called if she is younger than 18 years. The United Nations Convention on the Rights of the Child, signed by Tajikistan, clearly states that the best interests of the child and adolescent should be the primary consideration of the

health care provider. Furthermore, absence of a policy on sexuality education leaves adolescents with little support and few options for accessing information on sexual and reproductive health.

Other services delivered to adolescents consist mainly of routine screening, which is without proven benefit, rather than services according to global standards for quality health care services for adolescents. Dispenserization visits (a comprehensive system of examination and surveillance for all types of illness in the population) are mandatory and take place annually for all children aged 0–18 years, including adolescents.

Table 13. Adolescent birth rate per 1000 girls aged 15–19 years

Country	Adolescent birth rate
Norway	2.9 (2017 data)
Russian Federation	21.5 (2016 data)
Republic of Moldova	21.4 (2018 data)
Turkey	20.9 (2017 data)
Kazakhstan	25.6 (2018 data)
Tajikistan	54.3 (2016 data)

Source: Adolescent birth rate: data by country. In: Global Health Observatory data repository [online database]. Geneva: World Health Organization; 2019 ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adolescent-birth-rate-\(per-1000-women-aged-15-19-years\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adolescent-birth-rate-(per-1000-women-aged-15-19-years)), accessed 14 May 2019).

Legislation

Tajik law states that adolescents can provide consent for medical care from 16 years of age in order to receive health services, but in practice adolescents aged 16–18 years need parental consent to receive sexual reproductive services. Those who are pregnant and younger than 16 years are reported to the police; for girls younger than 18 years, parents are called.

Key informants reported that identifying the father of the fetus and forcing the adolescents to marry was a success. Confidentiality for adolescents receiving services is stated in the law, but there was discrepancy in practice when adolescents came to seek medical help without parental consent.

Contraception

The United Nations Population Fund provides contraceptives to reproductive health centres in Tajikistan, but no contraceptives were given directly to adolescent-friendly centres. Key informants also reported that they could only provide information to adolescents, and could not provide contraceptives in practice.

Abortion

Medical abortion is only allowed until the seventh week of pregnancy, and patients need prescriptions to get the relevant drugs. Without parental approval, however, no abortion-related services are provided to adolescents. Law enforcement is called if a girl is pregnant before the age of 16. For adolescents pregnant between 16 and 18 years, law enforcement may not be involved, but parents have to be called to notify them about the pregnancy and abortion.

Although adolescent-friendly centres were established to serve adolescents, key informants reported that only 1–3% of the patients visiting the centres are under the age of 18 years, and that the centres are mostly used by sex workers.

Table 14 sets out a summary of the assessment's findings on adolescent-friendly sexual and reproductive health services.

Table 14. Summary of findings on adolescent-friendly sexual and reproductive health services

Attribute	Rating	Considerations for rating
Protocols and legislation	Some need for improvement	National standards for adolescent-friendly health services have been developed, and the law reportedly allows service provision to those aged 16 and over. Legislation and protocols do not allow provision of services based on the maturity of the adolescent.
Scope of services	Considerable need for improvement	Services are not provided to adolescents. Medical abortion is allowed only up to the seventh week of pregnancy. Dispenserization visits are taking place, without proven benefit.
Population coverage and/or access	Considerable need for improvement	According to key informants 21 adolescent-friendly health centres have been established. Adolescents are not reached, however, and the main population group accessing sexual and reproductive health services is reportedly sex workers.
Quality of services	Considerable need for improvement	In practice, no services are provided to adolescents without parental consent. Routine screening without proven benefit is provided. Services are delivered in contravention of the United Nations Convention on the Rights of the Child.

Policy recommendations for SRMNCAH

The assessment showed that not all essential SRMNCAH services are provided with adequate quality at the relevant level, at no or affordable cost to the patient. This results in barriers to access to essential SRMNCAH services, and some patients seek alternative ways of obtaining treatment, including bypassing PHC or using the private sector; this may lead to a growing parallel system, exacerbating health inequities.

Savings and efficiency gains in service organization, delivery and financing are crucial to ensuring greater coverage of SRMNCAH while safeguarding the quality of services provided. The recommendations proposed below are intended to provide a basis for policy changes and implementation arrangements along the essential pillars of UHC, with a focus on SRMNCAH.

Strengthening governance for SRMNCAH

A wide number of protocols based on evidence and international guidelines have been developed for SRMNCAH. Despite this, over-hospitalization of patients with ambulatory-sensitive conditions, which could be treated better and more efficiently at the outpatient level, is a major challenge.

The assessment team recommends the following.

- A greater proportion of GDP should be spent on health care services, resulting in greater access to high-quality care.
- Implementation of a financing system that pools resources for health, is based on solidarity principles protecting the poor and most in need and allows for a health workforce essential for the development of the country is recommended.
- Evidence-based guidelines and protocols for when to admit and refer patients to hospital should be followed, and measures put in place for their re-enforcement at both the PHC and hospital levels.

- The system of ambulance and emergency transport to hospitals should be reviewed, including compliance with standards and norms for ambulances (including adequate space, functionality and equipment for care during transport, and sufficient ambulances to meet the needs of population), protocols for interfacility transfer criteria and compliance monitoring.
- The legislation on reproductive health and child protection should be reviewed to allow adolescents formalized legal access to more defined, autonomous, confidential, non-judgemental and appropriate health services.
- The way services are organized and delivered does not currently ensure sexual and reproductive health coverage for adolescents, and stronger political commitment is required to reduce existing inequities in sexual and reproductive health for adolescents and young people. A major effort should be made to improve availability of adolescent-friendly sexual and reproductive health services – including contraceptive services and commodities, emergency contraception, prevention and management of STIs and HPV immunization – without social and financial barriers.
- Health literacy activities and initiatives should be introduced in collaboration with the education sector (such as information on contraception and sexuality education, as well as use or misuse of antibiotics). Work should be done with communities to highlight evidence-based care, including use of oral medications for pneumonia and outpatient treatment of mild childhood illnesses.
- Engagement with religious leaders should be continued to allow access to adolescent sexual and reproductive health care.

Improving service delivery and strengthening evidence-based practice

The balance between resources spent on keeping available a large number of hospitals and beds and the need to strengthen the PHC level – and particularly ensuring adequate salaries for health workers – needs to be reviewed.

The assessment team recommends the following.

- Needs for and distribution of all existing health facilities, their location and human resources (including required competencies, skill mix, incentives and disincentives) should be reviewed. In particular:
 - services provided by feldsher-midwifery health posts should be assessed – concentrating resources to provide improved quality of care at family medicine centres and to ensure transport services should be considered;
 - home deliveries should be discontinued, and delivery care and management of obstetric complications at facilities with appropriately trained staff and the necessary equipment should be ensured, since certain functions – such as obstetric care, deliveries and intensive neonatal care – require a certain case-load per year to be performed safely;
 - provision of safe neonatal transport should be ensured throughout the country: as many regions of Tajikistan are rural and not easily accessible, to ensure safe delivery of neonates and transport for timely care, available road vehicles should be properly equipped for neonatal resuscitation.
- Treatment of common childhood conditions should be reviewed and should be subject to global, evidence-based standards. Use of intramuscular and intravenous antibiotics should be re-examined in the context of clinical presentation of cough, and more judicious use of pharmacological treatments should be considered for such patients.
- PHC services are often fragmented, resulting in multiple referrals, so access to high-quality comprehensive SRMNCAH services at the primary care level should be strengthened to ensure diagnosis and treatment. For example, the system for STI diagnosis and treatment should be reviewed in the light of advances in

rapid tests, moving towards point-of-care testing and treatment, with the aim of avoiding multiple referrals and fragmentation.

- Evidence-based practice should be strengthened at all levels. Non-evidence-based, costly and potentially harmful practices with unclear benefit, such as dispenserization, should be discontinued.

Adjusting health financing to improve support for SRMNCAH

Tajikistan currently spends only around 7% of its GDP on health, and government expenditure on health is only 2% of GDP, which is lower than the average for European Union and eastern European and central Asian countries, in both absolute and relative terms. At the same time, unnecessary interventions that are proven to be non-effective are practised and consume resources. The country maintains an extensive health care infrastructure that requires sufficient resources to be run efficiently. The situation is further complicated by different “pilots” being run in different regions of the country.

The government recognizes the challenge posed by high OOP payments and low government spending on health, and financial protection of the population remains a primary strategic objective.

The assessment team recommends the following.

- A health financing system pooling resources and protecting the population from financial hardship needs to be implemented countrywide. Entitlements should be realistic, transparent and understood by the population, and it should be ensured that services described in policies are actually provided.
- Health expenditure (government budget, OOP payments and informal payments) should be reviewed to:
 - increase the proportion of government health expenditure; and
 - reduce OOP and informal payments.
- The state benefit packages should be reviewed to provide one package (including public health programmes like those for immunization, tuberculosis, HIV, hepatitis C and similar).
- The existing health infrastructure and service delivery model should be reviewed to optimize the existing hospital infrastructure.
- Taking into account the specificities of the country’s geography, regionalization should be introduced, focusing on accessibility to secondary care (in line with geographical access restrictions rather than necessarily following administrative regions).
- The PHC provision model should be changed: instead of family medicine, multidisciplinary primary care groups should be introduced. Planning should include consideration of the following points.
 - Since almost 90% of the country’s territory is mountainous, this needs to be taken into account when planning optimization of health care infrastructure.
 - Multidisciplinary primary care groups seem to be the best option, especially in remote, hard-to-reach villages that are isolated from the rest of the country during the winter. Such groups may consist of a family doctor, paediatrician and obstetrician/gynaecologist.
 - When hospital deliveries cannot be ensured, midwives should be allowed to attend home deliveries, but should be equipped with special bags and skill sets.
 - Emergency transport needs to be developed.

Reducing OOP expenditure on essential medicines and health products for SRMNCAH

High levels of OOP expenditure indicate that not only uninsured people but also those who are insured face financial risks when accessing health care services. Informal payments for services should be discouraged. This

can only be achieved through transparent open dialogue, addressing the salaries of health care workers and the conditions in which they work. Physicians should be entitled to appropriate remuneration for delivery of services and paid appropriate wages for their work.

Pharmaceuticals are an essential part of any successful health programme. Provision of essential drugs for SRMNCAH services, specifically for socially vulnerable groups, may contribute significantly to a reduction in OOP payments, as well as improvements in health status.

The assessment team recommends the following.

- Provision of essential medicines should be reviewed to:
 - provide essential SRMNCAH drugs as a part of the BBP; and
 - plan and provide contraceptives free of charge at minimum to socially vulnerable and adolescent girls.
- The pharmaceutical market in Tajikistan needs to be regulated, as prices are high. The government needs to regulate both prices and the quality of the drugs provided.
- The capacity of doctors should be improved to reduce polypharmacy.

Strengthening human resources for provision of SRMNCAH services

A lack of human resources is perceived, with brain drain of the health workforce as a result of emigration; this is not equally distributed across the country. At the same time, in many settings health care workers see only a few patients per day.

The PHC system is built around family doctors as the main entry point to access health services, but in many instances this level is bypassed and/or does not fully function in a coherent way, causing fragmentation of services. Primary care providers have to play a critical role in supporting underserved patients in both rural and urban settings. For family doctors and general practitioners to fulfil this role, the task profile needs to be expanded and preservice medical education, postgraduate training and continuing professional development prioritized in key areas of population health.

The assessment team recommends the following.

- The existing workforce should be reviewed, and a plan developed for redistribution to ensure adequate number of nurses, doctors and specialists throughout the country and its regions, with adequate remuneration.
- The norms and need for staffing at all levels should be reviewed, and a process begun to phase out unused service delivery points to free up financial and human resources for more strategic use.
- An assessment of regional hospitals and clinics should be carried out, with the goal of restructuring provision of health care services to avoid overstaffing and ensure appropriate use of hospital and primary care facilities. Patient data should be analysed to predict the number of patient visits and inpatient admissions, as well as the consequent number of staff required to provide such services.
- Provision of housing, supported utilities costs, education for children and adequate mentoring, supervision and professional development should be ensured in underserved areas of the country.
- Remuneration of health workers should be reviewed to diminish the risk of migration and informal payments from patients.
- Preservice education should be ensured, including evidence-based practice for SRMNCAH – such as when to refer and indications for hospital admissions.

- Continuing professional development, with simulation drills of standard SRMNCAH consultations, normal delivery and management of obstetric, neonatal and child emergencies should be introduced.
- Specific in-service sessions on aspects of SRMNCAH care should be introduced, including rational use of antibiotics, medical eligibility criteria for contraceptive use, criteria for diagnosing and managing pregnancy and obstetric complications and evidence-based contraindications to vaccination.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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World Health Organization Regional Office for Europe
UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int